BIRTHING IN GIRAR JARSO WOREDA OF ETHIOPIA

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By

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DEDICATION

This dissertation is dedicated to the memory of my daughters Amanda and Dew-Natasha, in whose spirit I live. Thanks for giving me the experience of fatherhood, even for a brief time.

ABSTRACT

In many African countries, women's disempowerment and subjugation affect their reproductive health services utilization. This situation becomes even more problematic for women during their vulnerable moments of childbirth. Although copious literature exists on women's experiences in navigating socio-cultural, religious, economic and structural barriers during childbirth, there is paucity of literature on women's perceptions of childbirth globally. Extant studies generally focus on health professionals' and researchers' perspectives on childbirth. This case study was conducted in two rural communities in Girar Jarso woreda of Ethiopia to explore women's experiences and perceptions of childbirth. The purpose of this study was to understand the local contexts in which women live and their implications for women's choice of place of birth and/or birth attendants in Girar Jarso woreda. It is hoped that this study would inform efforts to improve maternity health services delivery and uptake in Ethiopia.

This case study was conducted within intersectionality theoretical framework. Data were collected through focus group discussions, in-depth interviews, observation, fieldnotes and cultural interpretations. The data were analyzed and interpreted through social constructionist epistemological lens. This study employed inductive thematic analytical approach. The findings of this study were presented under themes consistent with research questions and were later analyzed and discussed in detail.

The findings revealed that institutional birth is gaining popularity in Girar Jarso woreda in the face of socio-cultural, religious, economic, structural and personal barriers. The improvements in institutional birth can be attributed to the Ethiopian government's persistent efforts to improve maternal, newborn and child health through policies, programs and initiatives. Despite improvements, transportation, health system characteristics, communal decision-making, preference for traditional birth among others, impede efforts to increase institutional birth.

This study concluded that women's experiences and perceptions of childbirth in Girar Jarso woreda are varied. Women's powerlessness and men's dominant decision-making position in Ethiopian society affect women's birth experiences. To improve women's overall birth experiences, mechanisms need to be established to address patriarchy, women's rights, transportation challenges, and attitudes of health professionals towards laboring women. The health development program needs reconfiguration to involve men, elderly women and community leaders in reproductive health communication efforts. Efforts should be made to integrate traditional birthing practices into modern obstetric services in the health system. Finally, there is a need for greater collaboration between health extension workers, traditional birth attendants and women development armies in the delivery of community maternity health services.

Table of Contents

List of Tables

List of Figures

LIST OF ABBREVIATIONS/TERMINOLOGIES

AIDS Acquired Immune Deficiency Syndrome

ANC Antenatal care

CHW Community Health Worker

CHWs Community Health Workers

CIA Central Intelligence Agency

DFTAD Department of Foreign Affairs, Trade and Development

EDHS Ethiopian Demographic and Health Survey

EFMOH Ethiopian Federal Ministry of Health

EFY Ethiopian fiscal year

EmOC Emergency Obstetric Care

EsOC Essential Obstetric Care

Ethio Ethiopia

FBOs Faith-Based Organizations

FGD Focus group discussion

FGM Female genital mutilation

FGDs Focus group discussions

FIGO International Federation of Gynecology and Obstetrics

G8 Group of eight

HDI Human Development Index

HEP Health extension program

HEW Health extension worker

HEWs	Health extension workers
HIV	Human immuno-deficiency virus
IAG	Inter-agency group
ICM	International Confederation of Midwives
IMF	International Monetary Fund
Kebele	Smallest administrative unit in Ethiopia
MMR	Maternal mortality ratio
MNCH	Maternal, Newborn and Child Health
MDGs	Millennium Development Goals
NGO	Non-governmental organization
NGOs	Non-governmental organizations
PMNCH	Partnership for maternal, newborn and child health
PNC	Postnatal care
St.	Saint
SAP	Structural adjustment program
SAPs	Structural adjustment programs
SBAs	Skilled birth attendants
SDR	Special drawing right
TBA	Traditional birth attendant
TBAs	Traditional birth attendants
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
US	United States
WDAs	Women Development Armies
WHO	World Health Organization

Chapter 1: Introduction

1.1 Background and study context

The United Nations Millennium Declaration signed in September 2000, commits world leaders to eight (8) millennium development goals (MDGs). The fourth and fifth MDGs relate to the health of children under 5 years old and women in the reproductive age (15-49 years). Reducing under-five mortality rate and maternal mortality ratio by two thirds between 1990 and 2015 has proven intractable (WHO, 2015). While modest progress has been made globally towards achievement of this goal, reducing under-five deaths and maternal deaths to 1990 levels has proven elusive. Globally, it is estimated that half a million women die each year during pregnancy and childbirth, with almost 99% of these deaths occurring in developing countries (Abdella, 2010; Kebede, Gebeyehu & Andargie, 2013). A recently published World Health Organization's progress report revealed a sobering finding that every day in 2013, about 800 women died due to complications of pregnancy and childbirth (WHO, 2015). The report suggested almost all of these deaths occurred in low-resource settings and most could have been prevented. The proportion of births attended by skilled personnel is above 90% in 3 of the 6 world health organization regions (WHO, 2015). However, increased coverage is needed in certain regions, such as the WHO African region where the figure is still only 51%. According to the world health organization, the risk of a woman in a developing country dying from a maternal-related cause during her lifetime is about 23 times higher compared to a woman living in a developed country (WHO, 2015).

1.2 Study area

Ethiopia is the tenth largest country in Africa and has a total surface area of 1.1 million square kilometers (EFMOH, 2012; WHO, 2014). It is bordered on the north and north-east by Eritrea, on the east by Djibouti and Somalia, on the south by Kenya and on the west and south-west by Sudan. Administratively, the country is composed of nine regional states and two city administrations. These are subdivided into 817 administrative woredas (districts) which are further divided into around 16,253 kebeles[1], the smallest administrative units in the governance structure. Figure 1-1 is a map of Ethiopia showing its nine regional states.

[1] Kebele is the smallest administrative unit of Ethiopia similar to a ward, a neighborhood or a localized and delimited group of people. A kebele holds a population of 5,000 people.

Figure 1-1: Map of Ethiopia.
Retrieved September 12, 2013 from www.mapsofworld.com/ethiopia/ethiopia-political-map.html. Copyright 2012 by Maps of World.

In 2014, Ethiopia was ranked 173 out of 187 countries on the human development index (HDI, 2014). The country has a population of 94.1 million (UNDP, 2014). Ethiopia is one of the least urbanized countries in the world with 83.6 percent of the population living in the rural areas and only 16.4% residing in urban areas (EFMOH, 2012). Females comprise 49.5% of the total population, of whom 24% are in the reproductive age bracket (15-49 years). The average

size of a household in Ethiopia is 4.7 (EFMOH, 2012) and fertility rate is 5.23 (CIA World Factbook, 2014).

This case study was conducted in two rural kebeles in Girar Jarso woreda[2] of Ethiopia. The woreda is found in the North Shoa Zone within Oromiya region. The two kebeles selected for this case study were Adisge and Girar Geber. There are 17 kebeles in Girar Jarso woreda. The woreda has 3 health centers, 17 health posts and 1 private clinic. Woreda residents access comprehensive health care at the zonal hospital in Fiche, the *defacto* administrative capital of Girar Jarso woreda. According to data in Girar Jarso woreda health administration, there are 80,938 people living in the woreda. Forty-one thousand two hundred and seventy-eight residents are males and 39,660 are females. Of the 39,660 female population, 17,887 (45%) are in the reproductive age. There were estimated 2,752 pregnancies and 2,566 deliveries in 2013. There are 16,867 households in Girar Jarso woreda. Figure 1-2 is a map of North Shoa Zone showing Girar Jarso woreda.

[2] Woreda is the second-level administrative division in Ethiopia. A woreda usually holds a population of about 100,000 people or more.

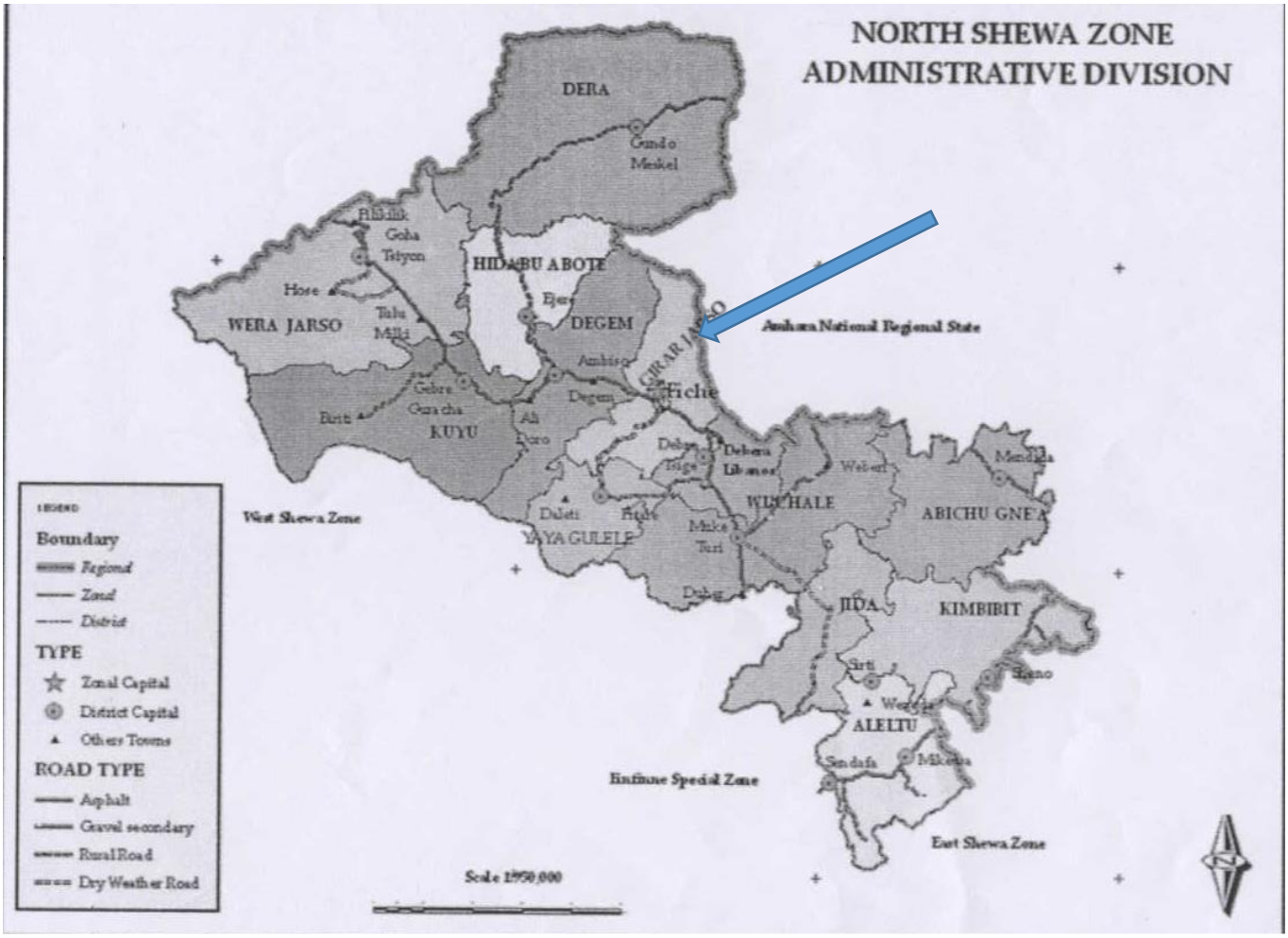

Figure 1-2: Map of North Shoa Zone showing Girar Jarso woreda.
Retrieved June 27, 2014 with permission from North Shoa Zonal Health Bureau.

Adisge, one of the kebeles for this case study is a low-lying community nestled in the Sefa river valley, 20 kilometers from Fiche. Until January 2014, Adisge had no motorable road and no ambulance service. Prior to construction of motorable road, residents accessed Fiche by walking or riding on horses. The terrain in Adisge is rugged. The road is winding, has no asphalt and becomes impassable to vehicular transport in the rainy season. There are 6,574 people living in Adisge of which 1,210 (18.4%) are women in reproductive age. Adisge has 1 primary

school and 1 health post. A diploma nurse and 2 health extension workers are employed in the health post. Residents access health care at the health post or health centers or hospital in Fiche. There are 38 sub-villages (Gotes) and 1,369 households in Adisge. Most residents are farmers. However, a few people in Adisge produce charcoal for living. People in Adisge speak Amharic language.

Girar Geber, the other study kebele is nestled in a mountain approximately 12 kilometers from Fiche and 32 kilometers from Adisge. Ambulance service to Girar Geber commenced in 2014. Residents usually commute by walking, riding horses or public transport. The road to Girar Geber is paved, has no asphalt and accessible year round. The population of Girar Geber is 6,131 of which 1,128 (18.4%) are women in reproductive age. Girar Geber has 1 health post at which 2 health extension workers are employed. Residents of Girar Geber may access health care at the health post, Ginno health center in a nearby kebele (45 minutes' walk away), or Fiche zonal hospital. Girar Geber has 1 primary school and 1 secondary school in the same compound. There are 27 sub-villages and 1,277 households in Girar Geber. Most of the residents of Girar Geber are farmers. Oromic language is spoken in Girar Geber.

1.3 Rationale for the Research

During the last two and a half decades, the Ethiopian government has intensified efforts to increase institutional delivery to reduce maternal and child mortalities through improvements in health services delivery, health promotion initiatives and free maternity health services in the public health system (EFMOH, 2012). Ethiopian government's targeted initiatives to improve maternal and child health included Safe Motherhood Program (1987), Making Pregnancy Safer (2000), Health Extension Program (2003), Reproductive Health Strategy (2006) and training of health officers with master of science (Msc) degree level training in skills of Integrated Emergency Obstetrics and Surgery (EFMOH, 2012). In 2012, the Government of Ethiopia renewed its commitment to address maternal and newborn health in a more comprehensive manner by developing a national Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia (EFMOH, 2012). Despite these persistent efforts, Ethiopia's maternal and child health indicators remain poor. According to the African Union, Ethiopia's maternal mortality ratio in 2013 was 420 per 100,000 live births and neonatal mortality rate for the same year was 28 per 1,000 live births (African Union, 2015). These numbers compare to maternal mortality ratios of 4 in Norway, 32 in China, 53 in Cape Verde and neonatal mortality rates of 1.5, 5.5 and 12.2 respectively (WHO, 2015). The proportion of deliveries attended by skilled health professionals in 2013 (EFY 2005) was 23.1% (EFMOH, 2015). However, antenatal coverage (at least one visit) for the same year was 97.4%. About 85% of women deliver at home and about one in three use traditional birth attendants while the others are assisted by relatives and family members (EFMOH, 2015). The literature suggests there are instances when women continue to prefer home birth even when facility-

based delivery is available at minimal cost (Shiferaw, Spigt, Godefrooij, Melkamu et al, 2013). There seems to be a dissonance between women's uptake of antenatal care in health facilities and the prevalence of institutional delivery. This discrepancy may be attributed to socio-cultural, economic, distance and infrastructural factors that influence decisions about where women birth and who attends to their birth (Jackson, 2014; Abebe, Berhane & Girma, 2012). In order to increase institutional birth in Ethiopia, it is imperative for the government, health providers and other stakeholders to understand the contextual and personal influences on women's childbirth decisions. This study attempted to fill this gap by providing opportunity to understand the contextual influences on women's childbirth decisions, experiences and perceptions of childbirth in two rural kebeles in Girar Jarso woreda of Ethiopia. The recommendations of this study may inform efforts to improve quality, relevance and utilization of maternity services in Girar Jarso woreda, Oromiya region and Ethiopia.

1.4. Research Partnership

During my fieldwork, I established a complementary and rewarding partnership with Ethio-Canada Maternal, Newborn and Child Health (MNCH) Project in Ethiopia. The project is a 5-year multimillion dollar project funded by the Canadian government through the Department of Foreign Affairs, Trade and Development (DFTAD) to improve maternal, newborn and child health in Ethiopia. The project is led by University of Alberta with support from other Canadian Universities including University of Saskatchewan and Mount Royal University in Calgary, Alberta. The local partners of Ethio-Canada Maternal, Newborn and Child Health Project (Ethio-Canada MNCH Project) include amongst others, the Ethiopian Federal Ministry of Health, Ethiopian Midwives Association, Ethiopian Public Health Association and St. Paul's Hospital

Millennium Medical College. It is important to note that although I was not an official member of the Ethio-Canada MNCH Project team, the complementarity of my doctoral research and the goals of Ethio-Canada MNCH Project allowed the two projects to share useful information to drive their respective agendas. My doctoral research is based at the University of Saskatchewan in the Department of Community Health and Epidemiology. During my visits to Ethiopia, I had the opportunity to consult for and volunteer with Ethio-Canada MNCH Project in North Shoa Zone in Ethiopia to collect baseline information on maternal, newborn and child health indicators as well as conduct referral-needs assessment. Girar Jarso woreda (where my doctoral research is located) is part of North Shoa Zone. The partnership with Ethio-Canada MNCH Project allowed me to collect pertinent information and expand my knowledge beyond the scope of my doctoral research and to learn more about Ethiopia's health care system and organization, maternal and child health indicators, Ethiopia's cultural diversity, the role of traditional birth attendants, women development armies (WDAs), [3]and maternal referral system, to name a few. Similarly, the partnership allowed me to contribute to a wider national maternal, newborn and child health initiative while focusing on my doctoral research. The partnership with Ethio-Canada MNCH Project offered me the opportunity to attend meetings with senior policy-makers at the Ethiopian Federal Ministry of Health, North Shoa Zonal Health Bureau and several woreda health administrations. These meetings gave me visibility, support and recognition for my research in Girar Jarso woreda of Ethiopia. In addition, through interaction with health professionals at different levels within the government structure in

[3] Women Development Armies is a network of women volunteers working across Ethiopia (especially in rural settings).

Ethiopia, I gained insight into current policies and programs to strengthen healthcare delivery and in particular to improve maternal and child health in Ethiopia. My consultancy and volunteer services with Ethio-Canada MNCH Project allowed me to visit some of the rural areas in Ethiopia where I learned first-hand about the context in which women live and birth. I travelled on the rough, unpaved roads, visited the under-resourced health facilities and spoke with community residents in their natural settings. These sobering experiences gave meaning and relevance to my doctoral research and I left Ethiopia with the determination to return to Africa in the near future with an expanded maternal and child health research agenda.

1.5 Objectives of the Research

This case study utilized intersectionality theoretical framework to gather data from five groups of women in Adisge and Girar Geber kebeles of Girar Jarso woreda. The five women groups were health extension workers,[4] grandmothers, traditional birth attendants,[5] women with home birth experience, and women with health system birth experience. The overarching purpose of this case study is to understand the local context, women's experiences and perceptions of childbirth in Girar Jarso woreda of Ethiopia. It is my hope that the study would inform efforts to improve the quality, relevance and utilization of maternity health services in Girar Jarso woreda, Oromiya region and Ethiopia. The five objectives delineated for this case study are as follows:

[4] Health extension workers are a cadre of health care providers who work in rural areas in Ethiopia. They are the pillars of the health development program and provide a range of community health services.
[5] Traditional birth attendants are usually elderly women who work in rural, remote and other medically-underserved areas in Ethiopia. They may or may not be trained in basic midwifery. They provide basic health care, support and advice during pregnancy, childbirth and after childbirth.

1. To improve understanding about women's experiences and perceptions of birthing[6] in Girar Jarso woreda.
2. To identify the contextual influences affecting birthing choices in Girar Jarso woreda.
3. To discern the perceived value of birthing at home in Girar Jarso woreda.
4. To identify women's motivations for utilizing maternity health services in Girar Jarso woreda.
5. To create a forum for discussion on birthing practices among women participants and to share knowledge on birthing practices in order to improve understanding by maternal health services providers in the Oromiya region and Ethiopia.

1.6. Research questions

In order to gather relevant data to satisfy the objectives of the case study, the following research questions guided my thesis:

1. What are the contextual influences on women's choice of place of birth and/or birth attendant in Girar Jarso woreda?
2. What are women's experiences and perceptions of birthing in Girar Jarso woreda and how do those influence their choice of place of birth and/or birth attendant?
    a) What do women value about birthing at home?
    b) What motivates women to engage with health system during childbirth?

The first research question allowed me to explore the contextual and intersecting factors that impact women's birthing decisions in Adisge and Girar Geber kebeles of Girar Jarso woreda. The second research question was helpful for me to explore women's childbirth

[6] Birthing is the constellation of decisions, actions and experiences that relate to the delivery of a child.

experiences, preferences and perceptions and how they influence women's choice of place of birth and/or birth attendants. Further, the second question facilitated discussions about what women value about home or health system birth, why some women engage with health system during childbirth and others do not. With the help of interview instruments guided by the research questions, I was able to gather childbirth stories, experiences and perceptions from different groups of women in Adisge and Girar Geber.

1.7. Conclusion

In this chapter, I provided a brief background of the global context of maternal and child health. The woeful failure of United Nations Millennium Development goals and governmental efforts to mitigate maternal and child deaths was mentioned in this chapter. The chapter highlighted the global disparities in the distribution of maternal and child deaths, with poor countries recording the highest number of deaths. I provided in this chapter a synopsis of maternal and child health context in Ethiopia, indicators, efforts made by the Ethiopian government to improve maternal and child health, successes and failures. In addition, I provided a snapshot of Girar Jarso woreda, Adisge and Girar Geber kebeles in order to illuminate the context in which this study was conducted. Further, in this chapter, I have articulated the rationale and objectives of this study. The research questions which guided the study and their import were presented in this chapter. Finally, in this chapter, I have described the opportunity I had to align my doctoral research with Ethio-Canada Maternal, Newborn and Child Health Project in Ethiopia and the benefits that accrued from this partnership. The remainder of the dissertation is organized under the broad headings of literature review,

methodology, findings, discussion, conclusion, references, and appendices. Chapters two to six consist of several subheadings which bring clarity to the reader.

Chapter 2: Literature review

2.0. Introduction

In this chapter, I provide literature review on childbirth from European, North American and African perspectives to highlight the similarities and differences in women's experiences and preferences during childbirth across cultures. The chapter elucidates global context of maternal health and provides scholarly discussion on barriers and facilitators of maternity health services utilization in different parts of the world. In addition, I provide in this chapter discussion on the impact of globalization, structural adjustment programs, poor governance, corruption and weak economies on health services delivery in developing countries. I discuss in this chapter the rights, empowerment and status of women globally and in Africa specifically in relations to decision-making and maternity health services utilization. Further, I discuss in this chapter various global initiatives that have been implemented in the last three decades to improve women's and children's health. The successes and failures of these initiatives are mentioned in this chapter. In this chapter, I provide extensive discourse on Ethiopia's maternal and child health indicators and health system organization. In addition, I describe the Ethiopian government's responses to maternal and child health. I conclude this chapter by drawing attention to paucity of literature on research that explores women's own perceptions and experiences with maternal health services delivery systems worldwide.

2.1 General overview

Childbirth is a social, emotional and personal event, which is inextricably linked with maternal and neonatal health. The health and well-being of a mother and child at birth largely determines the future health and wellness of the entire family (Cook & Loomis, 2012). The

literature suggests the way in which a woman experiences pregnancy and childbirth is vitally important for a mother's relationship with her child and future childbearing experiences (Fox & Worts, 1999; Hauck, Fenwick, Downie & Butt, 2007; Cook & Loomis, 2012). Perception of childbirth experience is highly personalized and women's views vary regarding what constitutes a positive and satisfying experience (Bryanton, Gagnon, Johnston & Hatem, 2008). Because satisfaction is multidimensional, women may be satisfied with some aspects of their birthing experiences and dissatisfied with others, and positive and negative feelings can coexist (Green, Coupland & Kitzinger, 1990; Waldenstrom, 1999; Bryanton, Gagnon, Johnston & Hatem, 2008). Albeit, Bryanton et al. (2008) assert that positive outcomes of the childbirth experience include increased self-esteem, confidence, mastery, attachment and maternal competence. Other studies suggest control, choice in decision-making, social support and efficacy of pain control contribute to women's retrospective attitudes towards their birth experience (Gibbins & Thomson, 2001; Hardin & Buckner, 2004; Hauck, Fenwick, Downie & Butt, 2007; Cook & Loomis, 2012). A study conducted in Northern Greece revealed that women's childbirth expectations are multidimensional and detailed, and concern issues related to pain, interventions, control, involvement, decision-making and supportive care (Sapountzi-Krepia, Tsaloglidou, Psychogiou, Lazaridou et al., 2011).

The history of childbirth has been recorded since A.D. 98 when Soranus, a great physician of Greco-Roman Era wrote a textbook of obstetrics that was used until the 16th century (Soranus & Temkin, 1991), and in China during Ch'ing Dynasty (Furth, 1987). While practices may vary from one culture to another, childbirth is viewed with joy, pride and celebrated across all cultures (Johnson, Callister, Freeborn, Beckstrand et al., 2007). From

antiquity until now, childbirth is also associated with complications, risks, fear, pain or death, but it is deemed a necessary bio-cultural phenomenon to perpetuate human life on earth (Essen, Johnsdotter, Hovelius, Gudmundsson et al., 2000; Tanglakmankhong, Perrin & Lowe, 2010; Sapountzi-Krepia et al., 2011). The North American literature suggests women adopt several coping strategies to confront their fears and anxieties about childbirth. A small segment of women choose to adopt home birth and use strategies including reliance on social supports, midwives, traditional birth attendants or significant other (Tarkka & Paunonen, 1996; Miller & Shriver, 2012). In hospital, some women craft their own "birth plans", hire doulas to advocate for their preferences in the hospital or select doctors based on their childbirth attitudes (McCourt, Weaver, Statham, Beake et al., 2007; Bryant, Porter, Tracy & Sullivan, 2007; Miller & Shriver, 2012). Still others choose elective cesarean birth (Boyle & Reddy, 2012).

African studies indicate structural, economic, cultural and geographic factors influence where women birth (Bazant, Koening, Fotso & Mills, 2009; Mselle, Kohi, Mvungi, Evjen-Olsen et al., 2011; Gething, Johnson, Frempong-Ainguah, Nyarko et al., 2012). In most societies in Sub-Saharan Africa where the dominant social structure is patriarchal, pregnant women are often not involved in arriving at the decision to seek care, whether from the traditional birth attendant or at health facilities (Mselle et al., 2011; Pfeiffer & Mwaipopo, 2013). Mselle and colleagues assert that, in such contexts, the decision about the place of birth and choice of birth attendant is the domain of the husbands or mothers-in-law. However, a rural Tanzania study revealed that in 7% of the cases a woman herself decided where to give birth (Mselle et al, 2011). This study corroborates with findings in Timor-Leste where women draw on their history, cultural identity and stories from their grandmothers to support their choice for place

of birth (Wild, Barclay, Kelly & Martins, 2010). Geographical distance from nearest health facility, poverty, limited decision-making power of women and belief in traditional birth attendants contribute to the high rate of home births in Africa (Mselle et al., 2011; Brighton, D'Arcy, Kirtley & Kennedy, 2013). The literature suggests a substantial proportion of women in Sub-Saharan Africa live beyond two hours from any facility likely to offer emergency obstetric and neonatal care (Bailey, Keyes, Parker, Abdullah et al., 2011; Gething et al., 2012). The preceding evidence suggests an African woman's birthing experience is influenced by pragmatism, contextualization and a complex array of intersecting social, cultural and structural factors.

2.2. Global Context of Maternal Health

Globally, it is estimated that half a million women die each year during pregnancy and childbirth, with almost 99% of these deaths occurring in developing countries (Kebede, Gebeyehu & Andargie, 2013). Regretfully, another 4 million newborns die and 3 million babies are stillborn (ibid). The vast majority of maternal deaths are due to direct obstetric complications such as hemorrhage, sepsis, complications of abortion, and hypertensive disorders of pregnancy, prolonged/obstructed labor, ruptured uterus and ectopic pregnancy (Paxton, Maine, Freedman, Fry & Lobis, 2005). Bailey, Paxton, Lobis & Fry (2006) assert that direct obstetric complications account for roughly 80% of maternal deaths globally. Research suggests that early and frequent antenatal care attendance during pregnancy help to identify and mitigate risk factors in pregnancy and to encourage women to have a skilled attendant at childbirth (Rutaremwa, Wandera, Jhamba, Akiror et al, 2015), and postnatal care improves the health of both the newborn and mother. According to World Health Organization (WHO),

maternal mortality is higher in women living in rural areas and among poorer communities (WHO, 2012). Furthermore, the WHO asserts that young adolescents face a higher risk of complications and death as a result of pregnancy than older women do.

The global distribution of maternal mortality ratio reflects the inequities in access to health services and highlights the gap between rich and poor countries (WHO, 2012). More than half and almost a third of maternal deaths occur in Sub-Saharan Africa and South Asia respectively, the poorest regions of the world. In 2012, the WHO reported that the maternal mortality ratio (MMR) in developing countries was 240 per 100,000 live births versus 16 per 100,000 live births in developed countries. Evidence suggests there are large disparities in MMR between countries and within countries, between people with high and low income and between people living in rural and urban areas (Mekonnen & Mekonnen, 2003; WHO, 2012). This is partly due to unequal access of rural women to modern health care facilities, skilled birth attendants and educational opportunities. Moreover, rural women in some parts of the world are highly influenced by traditional practices, which are contrary to modern health care (Roro, Hassen, Lemma, Gebreyesus et al, 2014). The most common obstacles to seeking obstetric care include financial barriers, challenges with transport, distance and socio-cultural factors (Jammeh, Sundby & Vangen, 2011). Unavailability and high costs of transportation, poor road conditions and time to arrange transport may increase the time to reach health facility or discourage its access.

One study in Ethiopia revealed that the most important factors that influenced the use of maternal health services were demographic and sociocultural in nature (Mekonnen & Mekonnen, 2003). The factors identified in this study included maternal education, marital

status, place of residence, parity and religion, which are similar to those documented in many settings throughout Africa and other developing countries. Gabrysch & Campbell (2009) corroborated these findings in a systematic review that identified sociocultural factors, economic and physical accessibility and perceived benefit/need of skilled attendance as the primary drivers of maternal health service use. The health-seeking behavior of women in many countries is enshrined in their social autonomy and freedoms. Some researchers have posited that women's lack of empowerment or ability to make their own choices may be a central reason for underutilization of health care (Sipsma, Callands, Bradley, Harris et al., 2013). The commonly used dimensions of women's autonomy include women's freedom of movement, discretion over earned income, decision making related to economic matters, freedom from violence or intimidation by husbands and decision making related to health care (Dharmalingam & Morgan, 1996; Bloom et al., 2001; Ghuman, 2003; Fotso, Ezeh & Essendi, 2009). Decision making power varies across cultures and may have implications for women's ability to access maternal health care. It has been hypothesized that higher autonomy of women would translate into improved health seeking behavior and consequently, into better health outcomes (Furuta & Salway, 2006; Fotso, Ezeh & Essendi, 2009; Woldemicael & Tenkorang, 2010; Woldemicael, 2010). However, a number of studies have revealed mixed conclusions on the effect of women's autonomy on various aspects of maternal health (Fotso, Ezeh & Essendi, 2009). For example, Bloom et al (2001) demonstrated that women's autonomy was a major determinant of maternal health care utilization among urban poor to middle-income women in a North Indian city. Similarly, Saleem and Bobak (2005) showed that decision-making autonomy was associated with contraception while movement autonomy was not. On

the contrary, while women's freedom of movement appeared to be a major determinant of maternal health care utilization among poor to middle-income women in a large urban area of Uttar Pradesh state in India, control over finances and decision making were not significantly associated with health services utilization (Bloom, Wypij & Das Gupta, 2001; Fotso, Ezeh & Essendi, 2009). These mixed findings suggest a study of maternal health care utilization among women in eastern countries, where women defer to their husbands, mothers-in-law and elders in matters regarding their health care is necessary. Similarly, a study of family and social support, concept of intergenerational continuity, health system factors and entrenched religious/spiritual traditions is necessary to understand the complex and multifaceted process of decision-making regarding women's health service utilization (Wild et al., 2010). The understanding of contextual factors is crucial to a sustainable effort to bridge the gap in maternal health between women in developing countries and their counterparts in developed countries.

2.2.1. Globalization and Health Services Delivery in Developing Countries

The global context of maternal health cannot be disaggregated from its parent-health services. Maternal health services require contextualization in the current era of globalization. Global financial, political and economic structures are the structural drivers of health systems and health inequalities in the world-including maternal health inequalities (Marmot, 2006; Marmot, 2007; Marmot, Friel, Bell, Houweling et al., 2008).

Globalization is a phenomenon that might have contributed to the slow progress towards the attainment of MDGs 4 and 5 (to reduce child mortality rates and to improve maternal health respectively) in developing countries. Globalization is defined as a process

through which increased levels of contacts are being made in economic, social and cultural areas between different countries (Siddiqui, 2012).The policies of globalization rely largely on trade, multinational corporations (MNCs), foreign investment and international finance. The forces of globalization have opened up the markets in developing countries to intense competition from multinational corporations. As a result, domestic sectors in developing countries are struggling to survive in the face of technological, economic and political challenges posed by vibrant foreign investors and trade liberalization (Hanson & Harrison, 1999). In the global open market, poor countries experience competitive challenges from affluent nations in terms of pricing and product/service quality. Foreign business entities use advanced technologies to offer quality goods and services at competitive prices in international markets (Milliou & Petrakis, 2011). This strategy negatively affects the economies of poor countries and may result in low health expenditure (including maternal health care) and poor auxiliary infrastructure development. In the past two decades, neoliberalism and multinational corporations' aggressive activities have resulted in the collapse of domestic industries in developing countries and weakened economies in others, and threatening their health systems (Siddiqui, 2012). Multinational corporations wield tremendous power over governments in poor countries, repatriate profits and enjoy unfathomable privileges in their host countries. This neoliberal disposition has the potential to thwart the achievement of MDGs 4 and 5. When multinational corporations and other foreign investors repatriate their profits, they leave the host countries poor. The resulting poverty undermines host countries' governments' investments in subsidies and social programs including investments in maternal and child health (Vos & De Jong, 2003).

2.2.2. Evaluation of Global Policies and Health Care Delivery Strategies

There is a need to evaluate the health impact of globalization, global health policies implementation and health care delivery strategies in order to understand the disparities in health between rich and poor countries. A narrow focus on health as disjointed from social, economic, political and human rights abuses is fallacious and undermines global health policies. The Alma Ata Declaration, Safe Motherhood Initiative, Millennium Development Goals 4 & 5 and globalization policies have failed to achieve rapid progress (especially in developing countries) because of their lack of focus on the social determinants of health (Labonte & Schrecker, 2007; Feldbaum, Lee & Michaud, 2010). Health programs cannot succeed in a vacuum. They need to be aligned with social, economic and political environments and framed in pragmatically sustainable manner. Global maternal health policies may succeed in achieving their goals if they are implemented in tandem with social, economic and political programs that are sensitive to the contexts, norms and practices of different countries (Murphy, Goma, Mackenzie, Bradish et al, 2014).

2.2.3. Structural Adjustment Program and Health Services Delivery in Developing Countries

Since the beginning of the 1980s, the World Bank and International Monetary Fund (IMF) have promoted structural adjustment programs (SAPs)[7] as economic policies for developing countries. SAPs aimed at integrating developing countries into the world economic system (Geo-Jaja & Mangum, 2001). The SAPs policies reflect the neo-liberal ideology that drives globalization (Hossen & Westhues, 2012). Under a structural adjustment program (SAP),

[7] Structural adjustment programs are a package of economic and institutional measure designed to solve macroeconomic problems in developing countries by reducing government intervention in the economy, correcting the borrowing country's deficits and opening the country's economy to the global market.

developing countries are granted loans by the World Bank and IMF with conditionalities. SAP policies require borrowing countries to devalue their currencies, set low inflation targets, reduce government spending on social services (including health services), privatize state corporations, lower tariffs on imports, increase free trade and open up their economies to foreign competition among others (Serven & Solimano, 1993; Muuka, 1994; Sparr, 1994; Peabody, 1996; Fafchamps, 1996; Subramaniam, 1999; Hossen & Westhues, 2012). Undoubtedly, these conditionalities and interference of international monetary institutions weaken the economies of poor countries and paralyze their essential sectors such as the health care industry. For example, in Latvia, IMF's structural adjustment targets have corresponded to about 60% cuts to public sector wages, resulting in massive layoffs, while the health budget suffered a drastic 30% cut (Stuckler, Basu, Gilmore, Batniji et al., 2010). Therefore, to understand the global disparity in health care and the sluggish progression towards the attainment of MDGs 4 and 5 in poor countries, it is imperative to examine the impact of SAP policies on health services delivery and utilization.

Mbilinyi (1993) asserts that in Tanzania SAP policies (1986-1993) reversed achievements made towards decolonization of the economy, redistribution of wealth, provision of social services, racial equality and increased power of working people in the workplace and politics. The SAP's debt servicing policy, international economic exchanges and unequal power relationships between nations, drains capital from poor countries to affluent nations and in the process undermines social spending in the former (Amin, 1976; Kaminsky & Pereira, 1996; Deshpande, 1997; Muntaner, Salazar, Rueda & Armada, 2006). Further, the World Bank

and IMF lending policies favor European countries more than poor nations in Africa. A recent estimate presented to the European Parliament suggests more than 80% of IMF's new lending has gone to Europe, mainly Eastern Europe, where European banks are threatened and less than 2% of loans have gone to African countries (Stuckler et al., 2010). This crass injustice and the determination of neo-liberal powers to marginalize poor countries are at the root of the poor performance of health systems in developing countries.

2.2.4. Structural Adjustment Program in Ethiopia

Ethiopia joined the International Monetary Fund (IMF) on December 27, 1945 (IMF, 2015). While IMF has provided financial support to Ethiopia in the last 60 years, I will discuss the Funds' loans arrangement with Ethiopia between 1996 and 2019. Since 1996, the IMF has approved loans to Ethiopia to the tune of SDR 342.51 million (about US$459.74 million) of which Ethiopia has drawn SDR 283.53 million (about US$380.58 million). According to the IMF, Ethiopia's overdue obligations and projected payments to the Fund stood at SDR 161.72 million (about US$217.07 million) as of July 31, 2015 (IMF, 2015). Ethiopia is expected to repay its outstanding loan balance to the IMF by 2019 according to an agreed payment schedule. Inevitably, such payments will undermine the government's domestic spending on essential services such as education and health care.

2.2.5. Rights, Empowerment and Self-Determination of Women

In September 1994, the United Nations convened a conference in Cairo to address major issues related to population (McIntosh & Finkle, 1995 p. 223). Governments, religious organizations, women's advocacy groups and other non-governmental organizations played pivotal roles in determining the thrust and shaping the language of the Cairo document (ibid).

Since the Cairo International Conference on Population and Development, women's role in the areas of reproductive health and sexuality has been a priority issue (Woldemicael, 2010). In 1995, The United Nations convened an inter-governmental conference in Beijing on the subject of "Women's Rights as Human Rights" (Bunch & Fried, 1996 p. 200). The focus of this conference deviated from previous United Nations' conferences which were seen as primarily about women and development or even women's rights, but not about the concept of human rights as it applies to women (ibid). Bunch and Fried (1996 p. 200) assert that the activities of this conference and a parallel NGO Forum held some thirty miles away in Huairou culminated in the affirmation of the human rights of women, including women's rights to education, health and freedom from violence, as well as to the exercise of citizenship in all its manifestations. In July 2003, at the Maputo Summit of the African Union, held in Mozambique, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (known as The African Women's Protocol) was adopted by African Heads of State (Gawaya & Mukasa, 2005). The African Women's Protocol outlawed traditions such as female genital mutilation (FGM), widow inheritance and child marriages (ibid). Gawaya and Mukasa (2005) assert that the Protocol supports women confronting problems related to violence against women, HIV/AIDS and denial of women's health and reproductive rights. Further, the Protocol asserts the right of African women to live in a `positive cultural context' and their right to `enhanced participation in the determination of cultural policies' (Gawaya & Mukasa, 2005).

Ethiopia is signatory to many regional and international declarations protecting the rights of women. Paramount among these milestones is Ethiopia's ratification of the UN Convention on the Elimination of All Forms of Discrimination against Women and African

Women's Protocol (Africa News Service, 2015). In addition, Article 35 of the Ethiopian Constitution clearly stipulates the rights of women (ibid). The Africa News Service (2015) asserts that Ethiopian government has been promoting gender rights in its development policies and strategies to tackle the present inequality by formulating and adopting the Women's National Policy. According to the news service, Ethiopian government institutions were established at federal, regional and district levels to implement the policy. Historically, Ethiopian women who participated in the struggle to overthrow Mengistu Hailemariam's military regime in 1991 had full participation rights in all activities of the fronts and might have gained some decision-making power and rights (Woldemicael, 2010). However, Woldemicael asserts that participation in the struggle did not change women's subordinate status (particularly in rural areas), which is based on deep-rooted values and beliefs. As in many other societies in Africa, in Ethiopia, a woman's worth is measured in terms of her role as a mother and wife (Woldemicael, 2010). Like many women around the globe, Ethiopian women continue to struggle for their rights and self-determination. Notwithstanding the struggles against cultural traditions, Ethiopian women have made improvements regarding their roles and reproductive choices in recent years (Woldemicael, 2010). The establishment of the Union of Women's Association created institutional framework for mass participation in society (ibid).

The rights of women, autonomy and self-determination are critical to maternal health. Autonomy or self-determination involves an individual's capacity and freedom to act independently of the authority of others, for instance, the ability to leave the house without asking anyone's permission or make personal decisions regarding contraceptive use or obtaining health care (Woldemicael, 2010). Current policies towards improving maternal and

child health care are heavily tilted towards providing formal education to women with the hope that it will enhance their authority and consequently affect access to health care (Woldemicael, 2010). However, studies have shown that using proxy indicators obscure which dimension of autonomy is being measured as autonomy is composed of multiple dimensions, in which each dimension may be determined by different demographic and socioeconomic factors (Woldemicael, 2010). Mason (1984) as cited in Woldemicael (2010) purports that women's autonomy can be conceptualized as the ability to make and execute independent decisions pertaining to personal matters of importance to their lives or their family, even though men and other people may be opposed to their wishes. In many patriarchal countries, women are marginalized, powerless and cannot make decisions affecting their own lives (Bawah, Akweongo, Simmons, Phillips et al, 1999; Collumbien & Hawkes, 2000; Li, 2004; Pettifor, Measham, Rees & Padian, 2004; Stephenson, Bartel & Rubardt, 2012; Teferra, Alemu & Woldeyohannes, 2012). In such societies, women defer to their husbands or adult men for pertinent decisions about their health. Women's loss of their right to self-determination regarding their own health choices puts them in a precarious position. In many patriarchal societies, women's right to use contraception, the right to abortion, the right to seek health care is taken away or limited (Rutaremwa, Wandera, Jhamba, Akiror et al, 2015). Contemporary global maternal health policies have failed to sufficiently address the impact of gender inequality, human rights abuses, social, economic and political factors on health programming and access to health care by women (Subramaniam, 1999; Feldbaum, Lee & Michaud, 2010). Against this background, it is imperative for global maternal health policy-makers to consider all the barriers women face in their daily lives that affect their choices. Many authors have thus

suggested that maternal health policies and programming must empower women; give them voice in determining their own health decisions, choices and outcomes (Subramaniam, 1999; Feldbaum, Lee & Michaud, 2010; Stephenson, Bartel & Rubardt ,2012; Teferra, Alemu & Woldeyohannes, 2012) .

At the community-level, maternal health programming should be designed with full awareness of factors that influence women's uptake of health services. This approach tends to empower health professionals to break the socio-cultural, economic and traditional barriers that preclude women from making decisions about their own maternal health care. Therefore, the relationship between women, traditional birth attendants and skilled birth attendants in communities is an important area to explore to determine how it affects maternal health care delivery. Understanding these dynamics at the community/health system interface from women's perspectives will promote better use of health services and delivery of culturally competent and gender-sensitive maternal care (Ahluwalia, Schmid, Kouletio & Kanenda, 2003).

2.2.6. Global Response to Maternal Health

During the last three decades, global response to maternal and child health has been intensified. There has been increased effort by the United Nations and its agencies, governments, research institutions, International Confederation of Midwives, International Federation of Gynaecology and Obstetrics and other Non-Governmental Organizations (NGOs) to empower women and reduce maternal child mortality rates (Kwast, 1992; WHO, 2012; Adegoke, Mani, Abubakar & van der Broek, 2013). The 1978 primary health care concept and Alma Ata Declaration translated into the provision of improved antenatal care and training of traditional birth attendants (Hussein & Clapham, 2005). In addition, the primary health care

concept paved the way for decentralization of health care and increased the opportunity for private organizations, non-governmental organizations, faith-based organizations (FBOs)[8] and philanthropies to participate in health care delivery, especially in rural and underserved communities (Argaw, 2007; Sanders, Schaay & Mohamed, 2008). The Alma Ata Declaration identified community health workers (CHWs)[9] as one of the cornerstones of comprehensive primary health care.

In the 1980s, community-health worker programs mushroomed globally in the aftermath of the Alma Ata Declaration. Another cadre of workers, the voluntary health workers (VHWs)[10] became popular in developing countries in the 1980s in response to the community and rural health thrust. For example, in Africa, voluntary health worker initiatives were driven by the ideology of self-reliance, rural development and eradication of poverty and societal inequities (Werner, 1978). Unfortunately, the global economic recession in the 1980s seriously jeopardized the economies of developing countries. The economic downturn resulted in major policy shifts, introduction of austerity measures and erosion of government spending on social welfare (including health expenditures). By the 1990s, interest in CHW programs waned in the face of tight austere economic climates; resulting in the collapse of large-scale national programs. During the economic crises of the 1990s, numerous NGOs and FBOs continued to invest in mostly small, community-based health care in poor countries (Lehmann & Sanders,

[8] Religious organizations that provide health services, especially in rural and underserved communities in the world.

[9] Community health workers are trusted, knowledgeable frontline health personnel who typically come from the communities they serve. They bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes.

[10] Voluntary health workers are local people trained to offer unpaid services in provision of basic preventative and curative care services, usually in rural and underserved areas.

2007). However, interest in CHW programs picked up again around 2008 in response to increasing service needs, primarily due to the impact of the HIV/AIDS Pandemic and the increasing shortages of professional health workers (WHO, 2007). Since the re-initiation of CHW concept, CHWs have played critical role in community development and bridging the gap between the community and the formal health services in all aspects of health development (Lightowler, 2000; Maes & Kalofonos, 2013). Community health workers have made significant contributions to maternal and child health in rural and underserved communities where majority of the poor lives.

2.2.6.1. Safe Motherhood Initiative and Community Health Workers

In 1987, the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), the World Bank and other organizations jointly launched the Safe Motherhood Initiative in Nairobi, Kenya (Prata, Sreenivas, Greig, Walsh et al. 2010; WHO, 2012; Kwast, 1992). The Safe Motherhood Initiative brought maternal and child health to the forefront of global public health concerns. Among other goals, this initiative aims to reduce maternal mortality by 75% between 1990 and 2015 (Kwast, 1992; WHO, 2012). Both the Alma Ata Declaration and Safe Motherhood Initiative underscored the importance of community health workers in the delivery of maternal health care. These initiatives culminated in the training and inclusion of auxiliary health workers such as TBAs and CHWs in maternal health care. Despite the mass training of traditional birth attendants in many developing countries, their inclusion in maternal care is limited by a constant and concerted effort by cosmopolitan obstetrics to devalue their knowledge (Saravanan, Turrell, Johnson, Fraser et al, 2011). According to Jordan (1989), training programs for traditional birth midwives

(attendants) present cosmopolitan obstetrics as authoritative. This training paradigm renders Indigenous knowledge illegitimate and Indigenous ways of knowing invisible. The failure of cosmopolitan obstetrics practitioners to collaborate with traditional birth attendants and integrate their indigenous knowledge effaces the latter's role and authority in maternal care. The marginalization of traditional birth attendants in obstetrics care is contrary to the World Health Organization's recommendations as follows:

> *Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worth-while exploring the possibilities of engaging them in primary health care and of training them accordingly (WHO, 1978).*

The constant denigration of TBAs by cosmopolitan obstetrics undermines the goals of Alma Ata Declaration and Safe Motherhood Initiative. Both Alma Ata Declaration and Safe Motherhood Initiative recognized the phenomenal contributions of traditional birth attendants during childbirth in developing countries and supported their training and continuous inclusion in maternity health care delivery (Kruske & Barclay, 2004). The WHO actively promoted the training and recognition of TBAs throughout the 1970s and 1980s and members of the Safe Motherhood Inter-Agency Group (IAG) significantly influenced global policy development and funding support for birthing services and TBA training (Kruske & Barclay, 2004).

2.2.6.2. The impact of Safe Motherhood Initiative

In spite of improved attention and commitment to safe motherhood, several developing countries, particularly in Sub-Saharan Africa experienced on average little change in the percentage of deliveries assisted by a skilled attendant between 1989 and 1999 (AbouZahr & Wardlaw, 2001) and showed no signs of achieving the scheduled reductions in maternal mortality (World Bank, 2003). This phenomenon requires a critical scrutiny of national and regional policies around maternal health, programs content and implementation modalities and a plethora of factors that inhibit access to maternal health care in poor countries. Critics assert that the Safe Motherhood Initiative was implemented in haste with lack of evidence on the relative effectiveness of interventions in terms of their impact on maternal and neonatal mortality, particularly for those interventions that prevent and treat common causes of these deaths in developing countries (Hussein & Clapham, 2005; Prata et al., 2010). Hussein and Clapham (2005) assert that international organizations and institutions implementing safe motherhood programs in developing countries may have competing interests and differing perspectives. The literature suggests information reaching program implementers can be confusing and contradictory, leading to disruptions in efforts to implement and coordinate program activities in countries (Hussein & Clapham, 2005). The disagreement on terminology and interpretation of concepts appears to stifle the success of safe motherhood initiative. For example, there appears to be confusion about Essential Obstetric Care (EsOC) and Emergency Obstetric Care (EmOC), two concepts at the heart of the Safe Motherhood Initiative. While EsOC is the standard care provided for all mothers and babies during childbirth, EmOC is the specialized care provided for mothers and babies with complications at childbirth (Otolorin,

Gomez, Currie, Thapa et al, 2015). Clarification of distinction between these concepts is paramount to provision of safe obstetric care (Otolorin et al, 2015; Islam & Yoshida, 2009). Knowledge about the distinction between EsOC and EmOC will inform training, resource allocation and service delivery in health care facilities and community settings (Otolorin et al, 2015; Islam & Yoshida, 2009).

2.2.6.3. Safe Motherhood Initiative, Skilled Birth Attendants and Traditional Birth Attendants

The Safe Motherhood Initiative advocates the importance of skilled birth attendant at every delivery. A skilled birth attendant is defined as an accredited health professional (midwife, doctor, nurse) who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancy, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborn babies (WHO, 2004; Harvey, Ayabaca, Bucagu, Djibrina et al., 2004; Thomson, 2005; Adegoke, Hofman, Kongnyuy & van den Broek, 2011; Edmonds, Hruschka, Bernard & Sibley, 2012). Traditional birth attendants (TBAs), trained or untrained are not defined by World Health Organization as skilled attendants (WHO/UNFPA/UNICEF, 1992; Carlough & McCall, 2005). Notwithstanding, the World Health Organization and United Nations recommended integration of TBAs in maternal health care in their Safe Motherhood and Millennium Development Goals (4 and 5) respectively. However, the current World Health Organization's Making Pregnancy Safer Initiative, focuses on skilled birth attendance, and emphasizes the need for professional competencies, training and skill development (Hussein & Clapham, 2005). According to the World Health Organization (2007), severe bleeding during childbirth, causes about 25% of maternal deaths in developing countries, making this the most common cause of maternal

mortality. The World Health Organization asserts that severe bleeding during delivery or after childbirth contributes to around 34% of maternal deaths in Africa, 31% in Asia and 21% in Latin America and the Caribbean (WHO, 2007). In 2007, the World Health Organization launched Safe Blood for Safe Motherhood Initiative in response to the high global maternal mortality related to intrapartum and postpartum hemorrhage.

2.2.6.4. The Millennium Development Goals

In 2000, the United Nations launched the millennium development goals (MDGs). The MDG 5 committed member countries of the United Nations to reduce maternal mortality by three quarters between 1990 and 2015 (Lozano, Wang, Foreman, Rajaratnam et al, 2011). In addition, MDG 5 aspires for universal access to reproductive health by 2015. Two and half decades after the launch of the millennium development goals, there is gross inequity in global maternal mortality ratios between developed and developing countries (Lozano et al, 2011). These inequities persist in spite of the tremendous effort of the international health organizations. The international Confederation of Midwives (ICM), International Federation of Gynaecology and Obstetrics (FIGO) and other Non-Governmental Organizations (e. g. Family Health International); have worked along with the World Health Organization, United Nations, The World Bank and governments to achieve MDGs 4 and 5 in recent years. According to the millennium development goals report released in 2013, global maternal mortality has declined by nearly half since 1990, but falls short of the MDG target (United Nations, 2013). The report indicated globally, maternal mortality ratio declined by 47 percent over the past two decades, from 400 maternal deaths per 100,000 live births in 1990 to 210 in 2010. Despite the improvement, in about 46 million of the 135 million live births in 2011, women delivered alone

or with inadequate care (United Nations, 2013). The report surmised disparities exist among regions and between urban and rural areas in the level of skilled attendance at birth. Recently, the World Health Organization reinvigorated its commitment to improving the health of women and children worldwide beyond the 2015 target (WHO, 2014).

2.2.6.5. The Partnership for Maternal, Newborn and Child Health

Another significant global response to maternal and child health is manifest in the launch of The Partnership for Maternal, Newborn and Child health (PMNCH) in September 2005. PMNCH strives for the achievement of MDGs (4 and 5) and supports partners alignment of their strategic directions and catalyze collective action to achieve universal access to comprehensive, high-quality reproductive, maternal, newborn and child health care (WHO, 2013). In 2012, the World Health Organization launched a new approach to promote and facilitate the institutional mainstreaming of gender, equity and human rights as the platform for its programming. This approach is geared towards enhancing WHO Country Office capacity to support countries in incorporating gender, equity and human rights within their national strategic health plans, other policies and activities on the ground and monitoring efforts (WHO, 2013).

2.2.6.6. The Muskoka Initiative

At a summit in June 2010 in Huntsville, Canada, development ministers of the G8 countries recommitted their countries and non-G8 leaders to intensify global effort to reduce maternal and child mortality and improve the health of mothers and children in the world's poorest countries (The Muskoka Initiative, 2010). During the summit, G8 and non-G8 partners committed a total of US$7.3 billion in new and additional funding over five years (2010-2015) to

accelerate progress on improving women's and children's health in developing countries (WHO, 2014). The Muskoka Initiative sparked international attention and intensified efforts by governments, international NGOs, civil society and United Nations to improve maternal and child health. In September 2010, the United Nations announced a US$40 billion Global Strategy for Women's and Children's Health aimed at helping the world meet Millennium Development Goals to reduce child mortality and improve maternal health (United Nations, 2010). A question that begs for attention is 'why is the world making slow progress towards achieving global maternal health targets despite colossal financial, material and moral commitments?` A plausible answer to this pithy question is given below.

2.2.6.7. Why a Slow Progress in Achieving Global Maternal Health Targets?

In an address, UN Secretary General Ban Ki-moon reiterated the global significance of maternal health and lamented that MDG 5 was the slowest moving of all the MDGs (Sullivan & Hirst, 2011). Several critics (Sachs & McArthur, 2005; Clemens, Kenny & Moss, 2007; Waage, Banerji, Campbell, Oona et al., 2010) have noted the lack of colossal success in the progression towards attaining the MDGs 4 and 5 on a global level and have called for careful assessment of gender and human rights issues. Maternal mortality is a human rights issue that is also associated with gender inequities (Freedman, 2001; Fathalla, 2006). For example, in Yemen, the harmful cultural practice of early marriage and premature childbearing is widespread and puts child brides' health at risk during pregnancy and childbirth (Callister & Edwards, 2010). Similarly, forty-seven percent of East Indian women marry before the legal age of marriage (18 years of age), and 71.6% are illiterate (Callister & Edwards, 2010). The slow progress in achieving MDG 4 and MDG 5 may be exacerbated by gender inequality, recurrent child-bearing

and gender-based violence, limited education regarding sexual health, family planning and maternal health and weak health systems with inaccessible, unaffordable or inadequate service delivery (Sullivan & Hirst, 2011). Gaps in key health care interventions for women including preconception care, family planning, prenatal care and skilled birth attendance contribute to the global rates of maternal mortality (Callister & Edwards, 2010). Callister and Edwards assert that lack of education, lack of health literacy, entrenched harmful cultural beliefs and practices and lack of life skills in many poor countries in the world contribute to the slow progress in achieving MDG 5.

2.3. Maternal Health in Sub-Saharan Africa

As previously stated in this dissertation, Sub-Saharan Africa continues to be one of the regions in the world where maternal and child health indicators are poor. The poor performance of maternal health in the region can be attributed to multiple reasons. Among the reasons are global political economy, poor governance, cronyism, and coup de tat, socio-cultural factors and weak infrastructure. The aforementioned obstacles have thwarted efforts by governments, international donors, non-governmental organizations (NGOs), researchers and civil society to improve the conditions in which women live and birth in Sub-Saharan Africa. Global economic policies have deprived developing countries in Sub-Saharan Africa from full participation in the global market. Neo-liberal market policies of globalization, structural adjustment programs and their stringent conditionalities undermine the economies and health systems of Sub-Saharan Africa countries. Poor post-colonial governance, corruption, nepotism and cronyism, strings of coup de tat, and meddling in African affairs by clandestine foreign security agencies created instability in Sub-Saharan Africa which ultimately weakened their

economies (Ayittey, 1999). With political instability and poor economic performance the health infrastructure of most Sub-Saharan Africa countries deteriorated in the aftermath of colonization. The recovery from these neo-colonial and imperial skirmishes, poor governance and weak economies has proven intractable in Sub-Saharan Africa. This has contributed to poor health care (including maternal health care) delivery in Sub-Saharan Africa. Compounding this problem are socio-cultural factors which discourage women from accessing maternal health care in health facilities (Sialubanje, Massar, Van der Pijl, Kirch et al, 2015; Tsawe & Susuman, 2014). It is important to mention that the poor maternal health indicators in Sub-Saharan Africa occur despite multiple global, regional and national maternal health policies, initiatives and programs.

Giving birth in a medical institution under the care and supervision of trained health-care providers promotes child survival and reduces the risk of maternal mortality (Fikre & Demissie, 2012). UNFPA (2004) suggests, in almost all countries where health professionals attend more than 80% of deliveries, maternal mortality ratio (MMR) is below 200 per 100,000 live births. Teferra et al (2012) assert about 80% of global maternal deaths are due to causes directly related to pregnancy and childbirth. The literature suggests that access to services such as antenatal care and skilled birth attendance in the African region are among the lowest in the world – a problem at the heart of this dissertation. Sub-Saharan Africa suffers acute shortage of the cadres of staff expected to provide skilled birth attendance including midwives, doctors and nurses. Adegoke et al (2013) assert Sub-Saharan Africa is in urgent need of estimated 700,000 midwives and about 47,000 doctors with obstetric skills. The acute shortage of health professionals with obstetric skills in Sub-Saharan Africa has resulted in preventable maternal

and neonatal deaths in the region (Scheffler, Mahoney, Fulton, Dal Poz et al, 2015; Gerein, Green & Pearson, 2006). In addition, social and cultural norms are known barriers to pregnant women's access to skilled birth attendants in Sub-Saharan Africa. In patriarchal societies[11] in Sub-Saharan Africa, a woman's social network (husband, father, guardians) act as gatekeepers for her maternal care. Therefore, the erosion of women's autonomy in Sub-Saharan Africa plays a significant role in where they birth and who attends to their birth.

2.3.1. Ethiopia's Maternal & Child Health Indicators and Health System Organization

Ethiopia like many developing countries in the world has suffered tremendously from the unfair global economic policies in the last three decades (Sasson, 2012; Peabody, 1996). As an agrarian economy, Ethiopia has suffered from the low prices of agricultural produce in the world market brought by market competition and improved production technologies. The restrictions of SAPs imposed on Ethiopian governments since 1945 have had negative implications for Ethiopia's economic performance and health services delivery. The stringent prescriptions of SAPs had forced Ethiopian governments to reduce investment in health care in the past with negative implications for maternal and child health. Notwithstanding, the Ethiopian governments in the past two and a half decades have made phenomenal progress in improving the health of its people. Through progressive policies, initiatives and programs, Ethiopian governments have demonstrated commitment and zeal to improve the health services delivery in their country (Ali, 2014). A number of policies, initiatives and programs targeted maternal and child health. As discussed elsewhere in this dissertation, Ethiopian

[11] Patriarchal societies consist of a male-dominated power structure throughout organized society and in individual relationships.

government's aggressive pursuit of Safe Motherhood Initiative, MDGs 4 and 5, and Health Extension Program is credited as a bold step to improve maternal and child health. Despite the modest improvements in maternal and child health in Ethiopia as a result of government policies, initiatives and programs; socio-cultural, economic, infrastructural and attitudinal factors impede efforts to attain the set targets.

According to Ethiopian Demographic and Health Survey (EDHS) 2005 and 2011, the proportion of women utilizing safe delivery service in the country is very low. The 2005 EDHS reported that in Ethiopia less than 6% of all women delivered at a health facility and that only 2.7% of women residing in rural areas delivered in the presence of a skilled birth attendant (Gessessew, Barnabas, Prata & Weidert, 2011). According to the (2011) Ethiopian Demographic and Health Survey report, only 34%, 10% and 6% women had antenatal care (ANC), delivery and postnatal care (PNC) by a skilled provider respectively (EDHS, 2011). The scarcity of skilled birth attendants (SBAs) and/or trained midwives in rural Ethiopia is a notable problem and well documented in the literature. The civil war waged in Ethiopia during the 17 years of military rule from 1974 to 1991 destroyed the country's health delivery system and the serious economic crises faced by Ethiopia at that time led to shortages of skilled health human resources, pharmaceuticals and health service delivery facilities (Banteyerga, 2011). Immediately after Emperor Haile Selassie was overthrown; in September 1974, a Military Committee (known as The Derg)[12] was established from several divisions of the Ethiopian Armed forces (Ethiopian treasures, 2015). The Derg implemented policies which included land

[12] The Derg meaning a "committee" is the short name of the coordinating committee of the Armed Forces, Police, and Territorial Army that ruled Ethiopia from 1974 to 1987.

distribution to peasants, nationalizing industries and services under public ownership and led Ethiopia into socialism (ibid). These policies at first gained mass support across Ethiopia. However, the popularity of The Derg regime did not live long due to ill sought out policies and mass executions. Ethiopia's economy under The Derg government plunged into recession due to civil wars with Eritrea and Tigray and invasion by Somalia (Ethiopian treasures, 2015). The internal unrest led to creation of splinter groups along tribal lines in opposition to The Derg regime. In addition, Ethiopia experienced severe drought in 1984/85 which led to famine. The aforementioned events caused social and economic instability in Ethiopia which ultimately undermined government investments in the health system. In recent time, the reluctance of skilled health professionals to work in rural communities in Ethiopia exacerbates the health delivery services in those settings. According to EFMOH (2012), the high rates of maternal and newborn mortality in Ethiopia results from a combination of a number of health and non-health factors. The Ethiopian health ministry asserts these factors include delays in making decision to seek health care, delay in reaching a health facility and delay in receiving care at the health facility. These delays result from varied factors such as inadequate number of skilled birth attendants, inadequate emergency obstetrics and newborn care services, weak referral system at health center and health post levels, financial barriers and socio-cultural values, cultural practices and beliefs (EFMOH, 2012).

Ethiopia's three-tier health delivery system is a decentralized system which shifts control of health services delivery from the federal government to regional and district (Woreda) administration (EFMOH, 2012). According to EFMOH (2012), the first level of district health system comprises of a primary hospital (with population coverage of 60,000-100,000

people), health centers (1/15,000-25,000 population) and their satellite health posts (1/3,000-5,000 population). The second level in the tier is made up of a general hospital with population coverage of 1-1.5 million people. The third tier consists of a specialized hospital that covers a population of 3.5-5 million people. A primary hospital and each health center with five satellite health posts form a Primary Health Care Unit. The decentralized health delivery system in Ethiopia shifts decision-making about health services delivery from the central government to regional and district health bureaus. The federal ministry of health and the regional health bureaus focus more on policy matters and technical support while Woreda health bureaus have basic roles of managing and coordinating the operation of the district health system under their jurisdiction (EFMOH, 2012). Figure 2-1 is Ethiopia's health system organization.

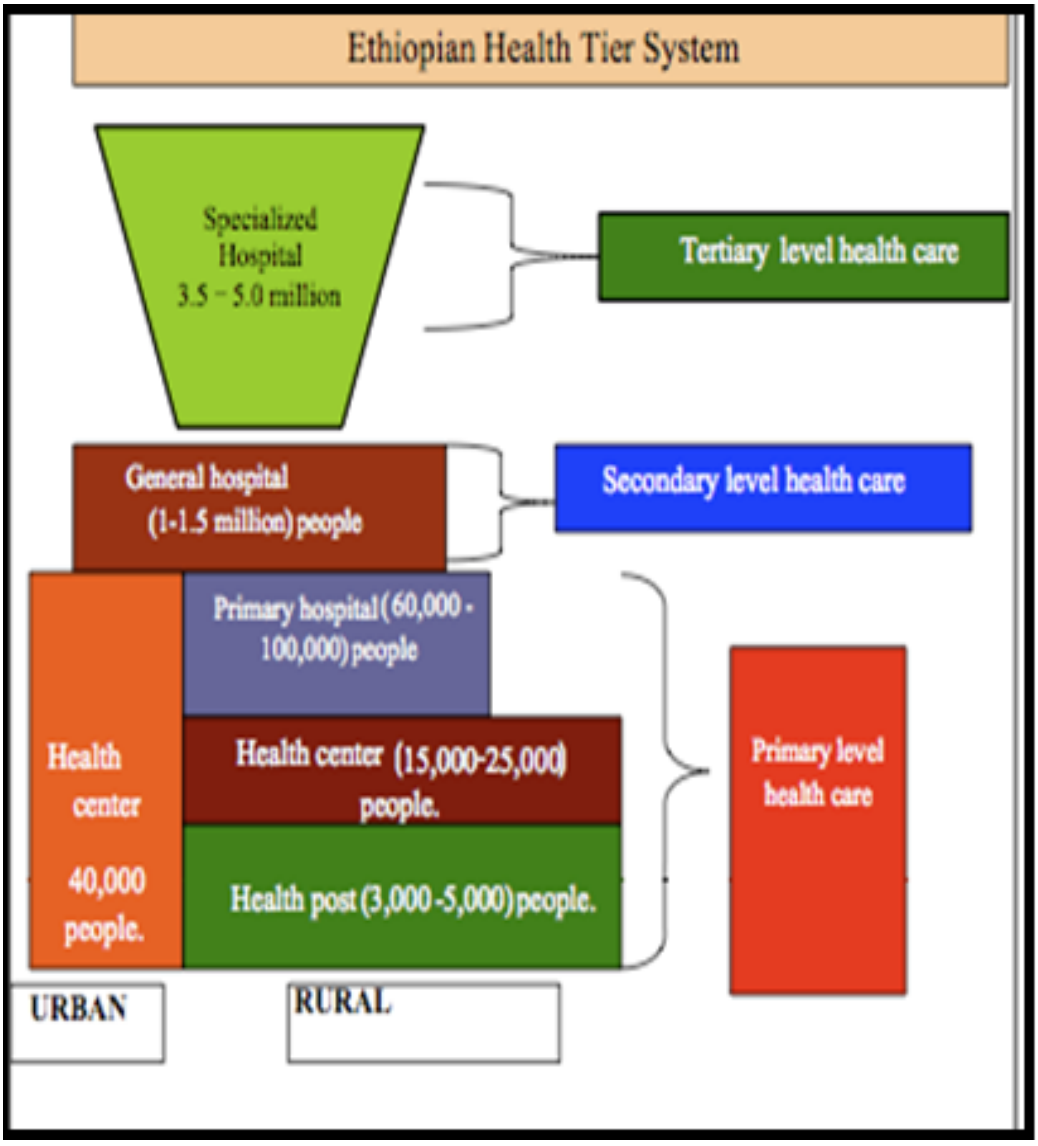

Figure 2-1: Ethiopia's Health System Organization.
(Adapted from the Federal Ministry of Health). Source: Ethiopian Federal Ministry of Health.

2.3.2. Ethiopian Government's Response to Maternal and Child Health

In 2003, the Ethiopian Federal Ministry of Health (EFMOH) introduced Health Extension Program (HEP)[13] to promote maternal and child health in rural communities. The HEP is one of the most innovative community-based health programs in Ethiopia. It is based on the

[13] Health extension program is an innovative community-based health care delivery system aimed at providing essential promotional and preventive health care services in Ethiopia.

assumption that access to and quality of primary health care in rural communities can be improved through transfer of health knowledge and skills to households (Argaw, 2007, EFMOH, 2007; Banteyerga, 2011). Against this assumption, the HEP creates model families based on families' adoption and implementation of HEP modules (Ulin, Robinson & Tolley, 2005; EFMOH, 2007). Each family receives 96 hours of training, involving face-to-face teaching and household visits in four modules corresponding to the four HEP subgroups: prevention of communicable diseases, family health services, environmental and household sanitation and health education & communication (Argaw, 2007 & Banteyerga, 2011). Under the family health services module, HEWs are trained to provide post-abortion care, family planning, antenatal care, delivery attendance (including referral of obstetric complications) and postnatal care (Gebrehiwot, Goicolea, Edin & Sebastian, 2012). As the model families change their health practices, they influence their neighbors and friends formally in venues such as community meetings and informally when they get together for social activities such as coffee ceremonies, funerals and home-building (Banteyerga, 2011).

The HEP was designed and implemented in recognition of the fact that a major factor underlying poor health services in Ethiopia is the lack of empowerment of households and communities to promote health and prevent disease (Bilal, Herbst, Zhao, Soucat & Lemiere, 2005). The core mandate of HEP was to train and deploy a new cadre of health workers (Health Extension Workers) to health posts in rural settings to meet the health needs of rural populations. The HEP complemented a training program for traditional birth attendants in Ethiopia and supplanted community-based health workers initiative (Banteyerga, 2011). The HEWs, the backbone of HEP, recruit voluntary community health workers as partners in the

implementation of the health extension program. The HEWs are required to spend 75% of their time conducting outreach activities by going from house to house and the remaining 25% of their time at the health post to provide antenatal and postnatal care, delivery, immunization, growth monitoring, nutritional advice and family planning as well as referral services to the general population of the kebeles (EFMOH, 2007; Dynes, Buffington, Carpenter, Handley et al., 2013). Banteyerga (2011) asserts that since the HEP became operational in 2004-2005, it enabled Ethiopia to increase primary health care coverage from 76.9% in 2005 to 90% in 2010. However, the author posits that in spite of a huge deployment of Health Extension Workers (over 30,578 HEWs by 2010), to rural settings, their services are scarcely sought by delivering mothers (Banteyerga, 2011). The home continues to be a delivery place of choice by majority of Ethiopian women, and the popularity of TBAs among rural mothers is remarkable. In response to the high rates of maternal and newborn mortality rates and to the global and African Union calls for each country to develop a country-specific Road Map, the Ethiopian Federal Ministry of Health in collaboration with its development partners developed a roadmap for accelerating the reduction of maternal and newborn morbidity and mortality in 2012 (EFMOH, 2012). The six specific objectives of the road map focus on achieving targets of major components of maternal and newborn health, and strengthening health system and the capacity of individuals, families and communities to improve maternal and newborn health (EFMOH, 2012). The six objectives are: a) To strengthen the capacity of individuals, families and communities to improve maternal and neonatal health b) To increase skilled attendance during pregnancy, childbirth and postnatal period c) Scale up the provision of basic and comprehensive emergency obstetric and newborn care d) Increase use of essential newborn care practices and newborn care services by

households e) Increase access to adequate information and family planning services at all levels f) To strengthen the health system management and partnership to deliver effective and efficient maternal and newborn health services.

2.3.3. Ethiopian Women: Gender, status and birthing choices

In agrarian settings in Ethiopia, men are traditionally the economic source, heads of their families and primary decision-makers (Bogale, Wondafrash, Tilahun & Girma, 2011). This privilege gives men authority over their spouses and this extends to decisions about maternal health choices of the latter. Senarath & Gunawardena (2009) assert women's decision-making autonomy within a household is central to utilization of health care services and maternal and child health outcomes. In Ethiopia, women's social position denies them autonomy in decision-making, economic independence and active participation in politics (Bogale, Wondafrash, Tilahun & Girma, 2011; Mabsout, 2011). In addition, highly unequal gender norms; products of gendered institutions reflect spousal relationships in Ethiopia where women are unable to play active role in decisions that affect their position (Mabsout, 2011). These intersecting factors render women powerless, marginalized and helpless in a patriarchal society.

The ascendancy of grandmothers, mothers and mothers-in-law in Ethiopian households give them power and control over where younger women in their families birth, what they eat or do not eat, what they do or do not do when pregnant (Thapa & Niehof, 2013). A study in Northern Ethiopia revealed that decisions regarding where pregnant women deliver, whom to call and when and where to seek help when complications emerged were strongly influenced by elderly women in the household, namely the mothers and mothers-in-law (Gebrehiwot et al, 2012). The study by Gebrehiwot and colleagues revealed that elderly women distrusted health

facilities and portrayed them as risky for birthing mothers and newborns. The elderly women argued that at health facilities birthing mothers were dangerously exposed to cold, which they believed delays uterine contraction and extends labor. As a result of these concerns, elderly women favor home birth which they believe provides comfort and appropriate support to the birthing mother and her newborn. Another study found that husbands advocate for their wives to birth in health facilities. Husbands believe the health facility is a safe environment for their wives to birth. As a result they advise their wives about institutional birth and arrange transportation when necessary (Thapa & Niehof, 2013). Given that 93% of births in Ethiopia occur in rural settings (Gessessew et al, 2011), it is important to understand the conundrums of mothers, their experiences and perceptions of childbirth and factors that impact their choice of place of delivery. There is copious literature about women's experiences in accessing maternal health care globally and in Ethiopia specifically (D'Ambruoso, Abbey & Hussein, 2005; Birmeta, Dibaba & Woldeyohannes, 2013; Igboanugo & Martin, 2011; Ha, Salama, Gwayuva & Kanjala, 2014). However, there is paucity of research exploring women's own perceptions of maternal health services delivery systems worldwide. These understandings will stem from childbearing women's experiences and perceptions of maternal health services delivery and the community/health system interface in their neighborhoods. It was against this background that I decided to interview women for this dissertation.

2.4. Conclusion

In this chapter, I have provided literature review on childbirth from European, North American and African perspectives. The chapter elucidates global context of maternal health and provides scholarly discussion on barriers and facilitators of maternity health services

utilization in different parts of the world. In addition, I have provided in this chapter discussion on the impact of globalization and structural adjustment programs on health services delivery in developing countries. This chapter examined global policies and their implications for health care delivery strategies. I discussed in this chapter rights, empowerment and status of women globally and in Africa specifically in relations to decision-making and maternity health services utilization. Further, I discussed in this chapter the various global initiatives that have been implemented in the last three decades to improve women's and children's health. The successes and failures of these initiatives were mentioned in this chapter. In this chapter, I have provided extensive discourse on Ethiopia's maternal and child health indicators and health system organization. In addition, I have described succinctly in this chapter, Ethiopia government's response to maternal and child health. This chapter is replete with references to numerous domestic, regional and international initiatives aimed at improving women's and children's health. I ended this chapter by drawing attention to paucity of literature on research that explores women's own perceptions and experiences with maternal health services delivery systems worldwide.

Chapter 3: Methodology

3.1. Brief introduction

This chapter provides overview of the theoretical and conceptual framework underpinning this research, the rationale for their choice and how they were applied throughout the study. The chapter also describes the research design, methods of data collection, analytic process and data interpretations that culminated in themes and discussions in this dissertation. In addition, this chapter explains meticulous steps that were taken to recruit and train research assistants, transcribers and translators and it chronicles the steps taken to select participants and choice of research sites. Further, the chapter highlights my preparation for fieldwork, challenges faced during data collection, strategies used to navigate challenges in the field and lessons learned. Also in this chapter, I explain the limitations and delimitations of the study and how they might have affected the study outcomes. Finally, this chapter describes ethical considerations that grounded the research protocol and steps that were taken to assure data quality throughout the study.

3.2. Theoretical framework

Increasingly, health researchers, policy-makers and practitioners concerned with sex and gender are acknowledging the importance of race/ethnicity, class, income, education, ability, age, sexual orientation, immigration status, and geography and are grappling with how to best conceptualize and respond to issues of differences among women and men and how these shape lives and health (Hankivsky, 2012). Intersectionality was introduced in the late 1980s as a heuristic term to focus attention on the vexed dynamics of difference and the solidarities of sameness in the context of anti-discrimination and social movement politics (Cho,

Crenshaw & McCall, 2013). The term intersectionality references the critical insight that race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities (Collins, 2015). Intersectionality has proven to be a productive concept that has been deployed in disciplines such as history, sociology, literature, philosophy and anthropology as well as in feminist studies, ethnic studies, queer studies and legal studies (ibid). Further, intersectionality has been strongly associated with women's studies, gender studies, cultural studies, media studies and other interdisciplinary fields with strong narrative traditions (Collins, 2015). A theory contains within it a method to arrange, prioritize and legitimize what we see and do; as well as it gives researchers space to plan and take control of the data and research process (Tuhiwai, 2001).

As an overarching concept, intersectionality has much to offer to population health in providing more precise identification of inequalities, in developing intervention strategies, and ensuring results are relevant within specific communities (Bauer, 2014). This study utilized an intersectionality theoretical framework to explore the socio- cultural, religious, geographical and structural factors that intersect to influence women's experiences and perceptions of childbirth in Girar Jarso woreda of Ethiopia. An intersectionality framework was appropriate for the research as the participants in the study were poor women, marginalized, mostly non-literate farmers who lived in rural settings in a developing country. Applying intersectionality theoretical framework to my research was appropriate as the study was conducted in Ethiopia, a country known for its patriarchal orientation (Bogale, Wondafrash, Tilahun & Girma, 2011; Berhane, Biadgilign, Amberbir, Morankar et al, 2011).

Intersectionality is a well-established paradigm for women's health research which places explicit focus on differences among groups and seeks to illuminate various interacting social, cultural, economic and political contexts that affect human lives, including social locations, health status and quality of life (Hankivsky et al., 2010; Read & Gorman, 2010). Similarly, Bowleg (2012) asserts that multiple social identities at the micro-level intersect with macro-level structural factors to illustrate or produce disparate health outcomes. The main argument proposed by intersectionality conceptual framework is that individuals do not share equal opportunities or equal conditions of living (Dillaway & Brubaker, 2006). Intersectional analysis names and describes hidden acts of discrimination and how they conceal damaging power relations and it brings to fore how multiple axes of injustice coalesce to impact the lived experiences of marginalized populations (Geerts & Tuin, 2013; Hovorka, 2012). This statement is consistent with the stories of some women in the study who indicated that they lacked power and control over their own bodies during childbirth. Intersectionality encourages investigations of numerous intersecting inequalities (including but not limited to gender), not only at the individual level but also at structural levels (Fotopoulou, 2012). Individuals and/or groups' access to resources, opportunities and power are structured by their particular "social locations" defined by race/ethnicity, class, gender, sexuality, age, national origin and other social structures of oppression and privilege (Dillaway & Brubaker, 2006). Most women in this study opined that families, neighbors and community elders had profound influence on where they birthed and who attended their childbirth. Intersectionality challenges practices that privilege any specific axis of inequality, such as race, class or gender and emphasizes the potential of varied and fluid configurations of social locations and interacting social processes in

the production of inequities (Hankivsky, 2012). Jackson & Williams (2006) assert that intersectionality theory provides a lens for understanding the full effects of these interactions and for revealing how power within gendered and raced institutional settings operates to undermine access to and use of resources that would otherwise be available to individuals of certain class standings. This was relevant to my study as all the participants were rural women, most of them were poor and non-literate farmers stripped of authority to make decisions concerning their reproductive health. Intersectionality has been used as a theoretical framework to study marginalized populations in many settings. In the United States, social science researchers have employed intersectional approach to study women of color, Latinas, immigrants as well as Lesbian, Gay, Bisexual and Transgender populations (Price, 2011; Viruell-Fuentes, Miranda & Abdulrahim, 2012; Parent, DeBlaere & Moradi, 2013). In India, a study investigated the intersections of gender and economic class to create nuanced understandings of the experiences and power among different subgroups within households to access health care for long term ailments (Springer, Hankivsky & Bates, 2012). A study in Botswana, used intersectionality as a framework to explore how women's powerlessness, marginalization in the labor market, unequal access to education, resource-allocation and decision-making affect their lived experiences (Hovorka, 2012). Price (2011) asserts that researchers can incorporate intersectionality when deliberating the choice of research topic, the kinds of research questions asked or hypotheses posed, the methods used, the interview and survey questions posed, the data sampling techniques used, and the coding strategy that will be developed.

The intersectionality theoretical lens was useful for me in developing interview guides for the study, choice of analytic method and interpretations and it allowed me to capture the

multiple factors that coalesce to affect women's birthing decisions, experiences and perceptions of childbirth in the study areas. Using intersectionality lens, I was able to rely on observation technique and interviews to gather information about the structural, personal and socio-cultural factors that affect women's access to maternity services in the study areas. In addition, by using intersectionality theoretical framework, I was able to place the multiple experiences and perceptions of women in the study at the center of data analysis (Bose, 2012). The fluidity of intersectionality approach requires researchers to constantly reflect on and probe their research strategies. Accordingly, I engaged in active reflection and group debriefing throughout the research to ensure that data collection, analytic and interpretation methods were appropriate. From an intersectionality perspective, multiple factors are always at play in shaping people's lives and health experiences. This notion was exemplified in this study through women's stories of diverse intersecting contextual influences on their childbirth.

3.3. Conceptual framework

The study was influenced by social constructionist epistemological framework. Young and Collin (2004) assert that social constructionism covers a range of views from acknowledging how social factors shape interpretations to how the social world is constructed by social processes and relational practices. The proponents of social constructionism share the goal of understanding the world of lived experience from the perspectives of those who live in it (Andrews, 2012). Social constructionist inquiry is principally concerned with explicating the processes by which people come to describe, explain or otherwise account for the world (including themselves) in which they live (Wu, Enders & Ham, 1997; Gergen, 1985). Social constructionism is a relativist epistemological position based on the notion of the social world

being constructed by individuals themselves through their social practices, rather than being a fixed and/or objective entity which is external to individuals and impacts on them in deterministic ways (Cohen et al, 2004 as cited in Fernando, 2012). From this perspective reality can be seen as an on-going and dynamic process, constantly reproduced by people acting upon their representations of it (ibid). Similarly, Puig, Koro-Ljunberg & Echevarria-Doan (2008) assert that constructive interplay between members of a community adds to the cultural sedimentation by producing new layers of cultural interpretations to existing forms of social reality. This notion was exemplified by participants' accounts of gradual changes in their living and birthing contexts and their reactions to them. Interview transcripts of women revealed that their birthing choices and experiences were co-created through interactions with families and community residents (Cromby & Nightingale, 1999). In addition, women in my study indicated that culture, history and physical factors contributed significantly to the birthing decisions they made. Gergen (1991) asserts that a meaning given to constructed reality determines the emotional and the behavioral response to it. Therefore, a study undertaken to explore experiences and perceptions of women living and birthing under conditions of uncertainty must take into account the women's ways of experiencing childbirth as well as personal, social and cultural context surrounding the experience (Shamai, 2003). During data analysis, I paid keen attention to women's construction of their childbirth experiences, the socio-cultural, economic, structural and geographical contexts in which they lived and birthed as well as women's expression of resilience in the face of daunting contextual challenges. The use of social constructionist conceptual framework for data analysis was appropriate as it allowed me to

carefully assemble women's childbirth accounts into cohesive themes for interpretation and report writing.

3.4. Research design

3.4.1. Qualitative methodology

A qualitative approach was used to explore women's experiences and perceptions of childbirth in Girar Jarso woreda of Ethiopia. This approach was used to uncover women's childbirth experiences, perceptions of childbirth and the intersecting factors that influence women's decisions about place of birth and choice of birth attendant. A qualitative method allows for a study of exploratory nature (Campbell, 2014; Jackson II, Drummond, Camara, 2007). This method of inquiry has been described as work done to understand "meaning" that is socially constructed by individuals in interaction with their world (Oliver-Hoyo & Allen, 2006). Cleary et al (2014) assert that qualitative research is undertaken in naturalistic settings and is interpretive in nature, with the collected information deriving mostly from interviews and observation. The intellectual premises upon which qualitative research methodologies are based are oriented towards exploring personal and/or interpersonal subtleties and sheds an interpretive light on the phenomenon under study to render it explicable to those who are not participants (ibid). This was achieved through focus group discussions, personal interviews, observational techniques and cultural interpretations of transcripts. Sargeant (2012) states that data collection methods most commonly used in qualitative research are individual or group interviews (including focus groups), observation and document review. The author posits that the methods can be used alone or in combination. Invariably, the purpose of research drives the selection of study methods (Zelko, Zammar, Ferreira, Phadtare et al., 2010). The choice of

above-mentioned qualitative methods for this research was consistent with my focus on expanding knowledge base on childbirth in Ethiopia and applying that knowledge by stakeholders to improve maternity health services in Oromiya region and Ethiopia.

Berg (2004, p.6) asserts that qualitative research allows the researcher to nominally, rather than numerically, seek pragmatic answers to questions by applying systematic procedures to data collected from individuals in particular situations. Similarly, qualitative method is used to understand people's beliefs, experiences, attitudes, behavior and interactions (Pathak, Jena & Kalra, 2013). Accordingly, I was more interested in how women conceptualized their childbirth experiences, perceptions about childbirth and the contexts in which they live and birth. Qualitative methodology was a useful approach to collect nominal information about real people in their natural contexts (Yin, 2003). The qualitative research instruments I used to collect data in the field will be discussed later. The decision to explore women's experiences and perceptions of childbirth from a qualitative perspective was appropriate since I was interested in contextual and personal factors that impact their childbirth experiences, how they navigate them and how they influence their perceptions of childbirth. Figure 3-1 is a framework which underpinned this study. The outer layer of the framework represents global and regional (African) contextual factors that significantly impact childbirth in Ethiopia. The middle layer represents national and district level contextual influences on childbirth. Finally, the core of the framework represents the main sources of data for this study and cultural icons in Adisge and Girar Geber kebeles who interpreted traditional birthing practices which emerged in participants' interviews.

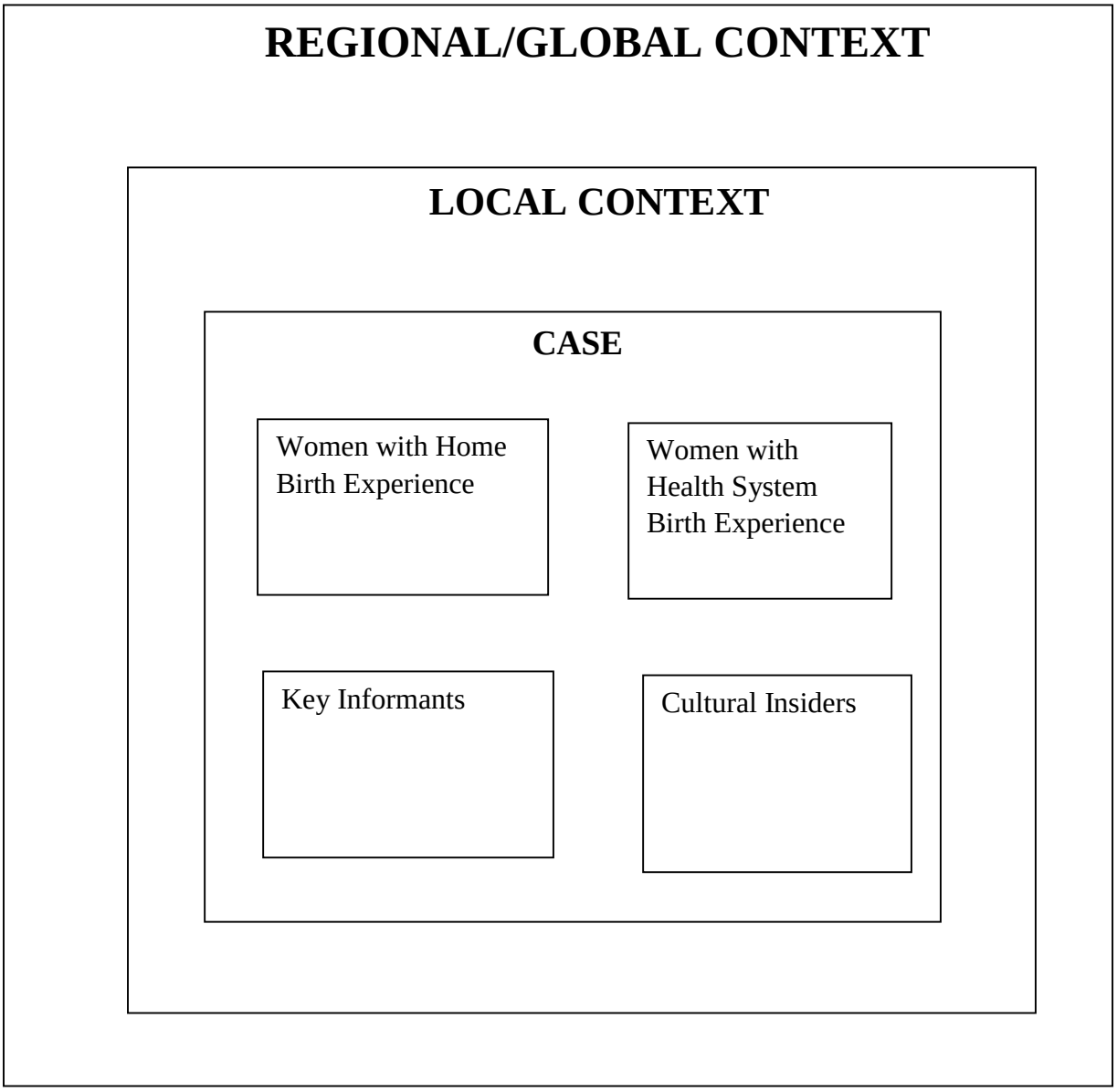

Figure 3-1: Study Framework.
Source: Adapted from Yin (2009, p. 46).

3.4.1.1. "Case study"

Regretfully, the term case study is a definitional morass (Gerring, 2004). However, it is undeniable that case study has become an accepted vehicle for conducting research in a variety of disciplines (Bergen & While, 2000). Gerring (2004) asserted that researchers have many

things in mind when they talk about case study research. The decisive factor in defining a study as a case study is the choice of the individual unit of study and the setting of its boundaries (Flyvbjerg in Denzin & Lincoln, 2011, p. 301). Hammersley (1989 p. 93) succinctly articulates the usefulness of case study by stating:

> *In essence, the term 'case study' refers to the collection of detailed, relatively unstructured information from a range of sources about a particular individual, group or institution, usually including the accounts of subjects themselves.*

Case study captures the circumstances and conditions of an everyday or commonplace situation that affect human life (Yin, 2009). According to Cousin (2005) intrinsic, instrumental and collective case studies are often used in qualitative research. This study employed instrumental case study approach. This study design enables exploration of issues and established points of view about these issues (Bullough Jr, 2015). It also enables identification of commonalities and differences within the boundaries defining a case (ibid). Instrumental case study examines a case mainly to provide insight into an issue or to redraw a generalization. The case is of secondary interest, it plays a supportive role and facilitates understanding of something else (Denzin & Lincoln, 2005 p. 445). I explored the case "childbirth" in the study areas (Adisge and Girar Geber) in order to shed light on the context and perceptions of childbirth in Girar Jarso woreda in general (Cousin, 2005). The intent of the instrumental case study was to gather data on women's experiences and perceptions of childbirth and to feed study findings to maternity health services providers and policy-makers in order to improve the birthing context of women in Girar Jarso woreda and Ethiopia. Instrumental case study approach was appropriate in order to understand the experiences and context in which women

live and birth through exploration of the perspectives of different groups of women (Gall, Borg & Gall, 2007 p. 547).

3.4.1.2. Cross-cultural preparation for data collection

Research begins mentally with the conceptualization and framing of research questions. An individual contemplating global health research needs to be psychologically attuned to the challenges inherent in conducting research in a foreign country. It is argued that students need to develop global health research competencies in order to be successful in conducting research in foreign countries (Hatfield, Hecker & Jensen, 2009). My research topic went through stages of conceptualization, confusion and refinement. When I decided on the research topic, I discussed it with friends and colleagues on campus to explore their perspectives. My Ethiopian friends provided useful insight into their country's maternity services provision, existing gaps and the role of traditional birth attendants. Prior to my first visit to Ethiopia, I familiarized myself with the literature about Ethiopia's culture, languages, geography, food and maternal and child health indicators (Hatfield, Hecker & Jensen, 2009). My Ethiopian roommate in Saskatoon provided insight into some of his country's cultural norms and etiquette. Stenson et al (2010) assert that it may be important for foreign investigators to learn the culture of the research site, be sensitive to local cultural norms and spend time in the community in order to earn the community's trust. Accordingly, I made two (2) trips to Ethiopia and the study district before commencing data collection. These trips allowed me to establish networks in the study woreda by connecting with community members and developing friendships. In addition, the trips offered me opportunity to familiarize myself with the climate and physical environment of the study district. My preparation for the fieldwork allowed me to practise being adaptive and

flexible, insightful, good listener and good observer and have a good understanding of the issues being studied (Yin, 1994).

3.4.1.2.1. Recruitment of research assistants

Researchers conducting global health research usually need research assistants to support the research protocol. The need may arise from numerous reasons including cultural, linguistic, gender or unfamiliarity with the research area (Shimpuku & Norr, 2012). All four factors mentioned above applied to my research scenario. I was a male cultural outsider, linguistically-challenged in the local languages, who wanted to conduct research with women in a patriarchal society. Therefore, it was necessary for me to recruit female research assistants who were cultural-insiders, familiar with the study areas, fluent in English and the source languages (languages of participants) and had the availability to support me in the fieldwork. The literature suggests that working with interpreters with similar social, cultural and linguistic background might facilitate the participants talking about research topics that could be private and sensitive for them (Weiss, 1994; Rubin & Rubin, 1995; Edwards, 1998; Shimpuku & Norr, 2012). Similarly, literature suggests that matching the characteristics of the interpreters and the participants might facilitate data collection because generally people from the same background share the same ways of expressing emotions (Jentsch, 1998; Murray & Wynne, 2001). In addition, matching the characteristics of interpreters and participants might promote trust to allow free flow of information, especially in cultures where certain sensitive topics are gender-oriented (Weiss, 1994; Edwards, 1998; Pitchforth & Tejilingen, 2005). Further, Murray and Wynne (2001) as cited in Shimpuku and Norr (2012) assert that matching the characteristics of interpreters and those of participants is important because interpreters could

create rapport with the participants based on cultural understanding. Given the fact that my research explored a sensitive topic of childbirth in a foreign culture, I hired research assistants based on their gender, socio-cultural and linguistic backgrounds as well as their experiences and familiarity with the study areas (Shimpuku & Norr, 2012). Finding suitable research assistants was a mammoth task. I approached my contacts within Addis Ababa University Selale Campus and health administrators in Fiche to recommend potential research assistants to me. The process proved difficult and frustrating as availability, family and professional responsibilities of people recommended to me did not allow them to commit to supporting me in the research. I eventually identified a female research assistant serendipitously in Fiche. This research assistant holds a bachelor's degree in psychology, works as project officer with a local non-governmental organization and has extensive qualitative research experience in the study kebeles. A second female research assistant was hired to assist me for three (3) days when the main research assistant had personal business to attend. The second research assistant holds a bachelor's degree in folklore, familiar with the culture of the study kebeles and has experience in qualitative research. Both research assistants were nulliparous, proficient in Amharic, Oromic and English. Due to the sensitive nature of the research topic, I believed it was appropriate to hire female assistants who could provide safe and comfortable presence for female participants to share their experiences and perceptions of childbirth (Juntunen, 2005; Shimpuku & Norr, 2012). To decrease potential for interpreter bias, I believed it was appropriate to hire nulliparous women who did not have personal experiences with childbirth but had interest in the topic of the study. Both research assistants received one day training about the research protocol and expectations (see Appendix A: schedule 1 for training manual).

3.4.1.2.2. Training of research assistants

The literature suggests that it is essential for interpreters to share the same understanding about the research topic and aims, the confidential nature of research, the interpreter's roles and responsibilities and the researcher's concerns (Shimpuku & Norr, 2012). To enhance the competency of research assistants and to strengthen the credibility of data, I provided one -day training for research assistants to prepare them for ethically sound and culturally appropriate data collection protocol (Shimpuku & Norr, 2012). The training entailed comprehensive description of the study purpose and objectives, kebele and participant selection criteria and data management procedures. The training emphasized the ethical responsibility for research assistants to be respectful to participants and people in the study areas, maintain privacy and confidentiality in the conduct of research. I advised research assistants to develop rapport with community leaders, participants and other inhabitants of the study kebeles in ways that demonstrate respect for them. The training emphasized the responsibility of research assistants to keep me in line with acceptable cultural practices in the study areas. Also, I encouraged research assistants to have attentive ears, good observational skills and write fieldnotes to capture what they hear or see in the research field. The training underscored the importance of punctuality and reliability of research assistants. Research assistants were informed about their responsibilities to liaise with health extension workers to arrange interviews with participants and to reschedule interviews when necessary.

The training also emphasized the need for research assistants to moderate interviews in a manner that allowed participants' voices to be heard in authentic but not distorted form. I instructed research assistants to ask questions verbatim from Amharic or Oromic interview

guides and use prompts and follow-up questions throughout the interviews to encourage participants to speak. In addition, the training emphasized that research assistants should refrain from editing questions. However, I informed the research assistants that if linguistic challenges required them to edit questions, they should exercise extreme caution to ensure that edited questions do not lose the intent of the original question. Issues of ethical process of explaining consent form, obtaining written or oral consent, and communicating participants' rights were given due consideration in the training sessions. Further, I asked research assistants to support me in welcoming participants at the beginning of each interview and thanking them at the end of an interview. Although I provided comprehensive one-day training for research assistants, I evaluated their competence throughout the data collection and gave additional training and clarification of their roles and responsibilities and my expectations as needed (Shimpuku & Norr, 2012). I set regular meetings with research assistants to re-confirm mutual understanding about the research protocol, aims, roles and responsibilities and expectations (Shimpuku & Norr, 2012).

3.4.1.2.3. Recruitment and Training of transcriber/translator

Being linguistically-challenged in the source languages for the study required that I recruited an individual who was fluent in the source languages (Amharic and Oromic) as well as English (target language) to transcribe and translate study data. The source languages were also *defacto* inquiry languages for this study. I recruited and trained a male transcriber/translator for the study (see Appendix A schedule 2 for training manual). The transcriber holds a bachelor's degree in economics and works in a government office in Fiche. He has extensive experience in qualitative research and high proficiency in written and oral English, Amharic and

Oromic languages. Data transcribers might be affected by transcribing heart-rending stories of distress (Lalor, Begley & Devane, 2006) as epitomized in stories of childbirth. The authors argue that a transcriber may engage with data and that individual engagement may precipitate emotions or a life-changing event. This sentiment was exemplified by a transcriber's quote from a research of Lalor et al., 2006.

> *While I find the situations that people are in quite upsetting and they often would bring me to tears as I am listening, they do on the other hand give me great respect for people who have to go through these very difficult times. I have become much less judgemental of people and the decisions they make, as I now realise that you just never know what is behind those decisions. That has been quite an attitude shift…and I admire the strength of these people involved.*

Given the fact that this study explored a highly emotive topic for women, I opted to use a male transcriber to minimize the potential for transcriber's bias or undue emotional burden (Lalor, Begley & Devane, 2006). After I recruited the transcriber, I provided a half-day training for him at Waaliyaa hotel in Fiche. The training entailed description of study purpose and objectives. I instructed the transcriber to transcribe interviews verbatim from voice to Amharic or Oromic text before translating them from the local languages to English language text to avoid loss of nuanced meanings. The training emphasized the ethical obligations for the transcriber to keep all research materials in his possession confidential. I informed the transcriber that his ethical obligation extended beyond audio-recorded interviews, transcripts, interview guides and emails to conversations with research team and information related to the research stored in his brain. I advised the transcriber not to discuss anything about the study with any person(s) without my

knowledge. Further, I informed the transcriber that to ensure quality of transcripts, I will hold periodic debriefing with him and a research assistant to compare transcripts against their audio-tapes. Also, I advised the transcriber to compare English and Amharic or Oromic interview guides with actual questions the research assistants asked participants in interviews as a peer review/check and balance. I advised the transcriber not to rush the transcription and translation processes as this could lead to loss of pertinent information or nuanced meaning. Further, I made it clear to the transcriber that at the end of the study, he had an ethical obligation to return all research artefacts in his possession to me and delete all email correspondence between us that contain information regarding the research. Finally, I informed the transcriber that at the end of the study he would sign confidentiality agreement form from the University of Saskatchewan.

3.4.1.2.4. Enlisting support of health extension workers

I obtained ethical clearance from the University of Saskatchewan and Oromiya Health Bureau in Ethiopia before I approached health extension workers in the study kebeles to enlist their support to recruit participants. In addition, I received support letters from North Shoa Zonal Health Bureau and Girar Jarso woreda Health Administration to conduct the study (see Appendix B). I received the telephone numbers of the health extension workers from the Deputy Director of Girar Jarso woreda Health Administration. A research assistant and I had meetings with the health extension workers at Waaliyaa hotel in Fiche. The location was convenient for the health extension workers as they lived in Fiche and commuted to the health posts in the study kebeles daily. We held separate meetings for health extension workers from Adisge and Girar Geber (two study kebeles). The initial meetings focused on enlisting their

support to recruit participants for the study. The health extension workers read the content of ethical clearance certificates and support letters I obtained from the University of Saskatchewan and government offices in Ethiopia before I described the purpose and objectives of the study to them. I thanked the HEWs when they agreed to support participant recruitment. I proceeded to ask them if they were also willing to assist with coordinating meetings with participants for interviews throughout the study. When they responded affirmatively to my request, with interpretation support from a research assistant, I explained to the HEWs the ethical principles and guidelines which governed the research protocol and encouraged them to abide by them throughout their involvement in the study. I provided snapshot of my expectations to the HEWs and they were further explained at training sessions on days and times agreed upon by them.

3.4.1.2.5. Training health extension workers

According to the literature, in Ethiopian society, it is culturally inappropriate to approach individuals to participate in research before obtaining permission from community leaders (Tekola, Bull, Farsides, Newport et al, 2009). As a result, I enlisted the support of HEWs to approach community leaders for permission to recruit women for my study. Wright et al (1998) as cited in (Kerrigan & Houghton, 2010) suggest that using a professional who is already well known to a group to act as mediator is particularly useful when recruiting marginalized groups into research, as it helps establish contact and trust between the researchers and participants. I advised the HEWs to explain the purpose and objectives of the study to community leaders before asking their permission for me to recruit participants. I instructed the HEWs to approach potential participants only after they had received approval from

community leaders. During the training sessions I reiterated the purpose and objectives of the study and asked the HEWs if they had any concerns about them. HEWs were given ample time to reflect on the study purpose and objectives before I answered their questions and clarified concerns they had about the research. Subsequently, I explained to them how their kebeles were selected for the study and why I was interested in interviewing only females for the research. I gave HEWs from Adisge participant invitation letters in English and Amharic. HEWs from Girar Geber received participant invitation letters in English and Oromic (see Appendix C). This was necessary since Adisge was Amharic speaking and Girar Geber was Oromic speaking kebele. I instructed HEWs to explain the purpose and objectives of the study to potential participants, answer any questions they may have and clarify their concerns or refer them to the Deputy Director of North Shoa Zonal Health Bureau. The HEWs had the telephone numbers for the Deputy Director. The training emphasized that HEWs should not coerce any woman to participate in the study. In addition, I encouraged HEWs to clearly explain the content of invitation letters to potential participants, answer their questions and address their concerns or refer them to the Deputy Director. I advised the HEWs to leave a copy of the invitation letter in the local language with every woman they approached to participate in the study. The training underscored the importance for HEWs to follow the study's inclusion and exclusion criteria when inviting women to the research. During the training I advised HEWs to inform recruits that they will be screened for language proficiency (mother tongue) and their selection for the study will depend on their performance in the screening interview. To avoid `gold rush'[14] to

[14] Gold-rush is feverish attempt by women in Adisge and Girar Geber to participate in this case study with intentions to benefit financially.

participate in the study, I instructed HEWs to inform women about honorarium after the women had voluntarily agreed to participate in the research.

3.4.1.2.6. Participant recruitment

After obtaining ethical clearance from University of Saskatchewan and Oromiya Health Bureau, I selected two kebeles, one each from the highlands and lowlands of Girar Jarso woreda. Although this research is not comparative study, I anticipated differences in women's experiences and perceptions of childbirth given the topographical differences between the two kebeles chosen for the study. I wrote the names of all seventeen (17) kebeles in the woreda on pieces of paper. The papers were grouped by lowland and highland and placed in separate boxes. I selected one kebele from each box for the study. The selected kebeles were Adisge (lowland) and Girar Geber (highland). After the study sites were chosen, a research assistant and I contacted health extension workers in Adisge and Girar Geber and invited them to a meeting in Fiche, the administrative capital of Girar Jarso woreda. The intent of the meetings was to solicit the help of the health extension workers to recruit participants for the study. Separate meetings were held for health extension workers from Adisge and Girar Geber. My research assistant briefed the health extension workers about the purpose of the research in their local languages. I responded to the questions of the health extension workers and clarified concerns they had about the study. The research assistant explained the inclusion and exclusion criteria to the health extension workers for clarification. The HEWs and I agreed on timeline for participants' recruitment.

3.4.1.2.7. Participant selection

Ethiopia has over eighty (80) languages and internal migration stemming from inter-tribal marriages and economic pursuit is common (Sereke-Brhan, 2005; Mberu, 2006). In consideration of this fact, potential participants were screened to determine their proficiency in the local languages for the study. Purposive sampling based on pre-defined inclusion criteria for enrolling participants was used. The inclusion criteria for the study were: a) Women aged 15 to 49 years in Adisge or Girar Geber who birthed in the last 2 years preceding the study regardless of their current pregnancy status (b) Grandmothers, traditional birth attendants and health extension workers willing to tell their experiences and perceptions of childbirth in their kebeles (c) Women with ability to comprehend and express themselves well in Amharic or Oromic. The exclusion criteria were: a) Women below age 15 or over 49 years old who birthed in Adisge or Girar were excluded from the study (b) Women in their reproductive age who did not birth in Adisge or Girar Geber were excluded from the study (c) Women who could not comprehend and express themselves well in Amharic or Oromic were excluded from the study. The participant pool had homogeneous and heterogeneous characteristics. The participants were homogeneous in the sense that they were mothers, lived in the same study kebeles and birthed under the same sociocultural, geographical and structural contexts. On the other hand, the participant pool was heterogeneous in the sense that the women were of different ages and parity levels. The homogeneity of the participants ensured that women provided rich and corroborating information about their childbirth experiences and the context in which they birthed. On the other hand, the age and parity differences of participants created opportunity

for the study to collect data which spanned across generations of childbirth experiences (Adler & Adler, 1988). Table 1 depicts the number of participants and their kebeles.

Table 1: Number of Participants

Kebele	Health extension workers	Traditional birth attendants	Grandmothers	Home birth in last 2 years	Health system birth in last 2 years
Adisge	2	5	5	10	7
Girar Geber	2	2	3	10	9

Potential participants attended selection interviews for language proficiency screening. Before the start of the interviews, I thanked the women for their time and interest in the study. A research assistant explained to women in their local languages the purpose of the study and invited the women to ask questions and/or express any concerns they had about the study and their participation. During the selection meetings, a research assistant informed the women that I had ethical clearance from University of Saskatchewan and Oromiya Health Bureau to conduct the study. Also, the research assistant informed the women that I had the support of North Shoa Zonal Health Bureau and Girar Jarso woreda Health Administration. A research assistant read the content of the ethical clearance certificates and support letters in local languages for the women. The potential participants received the telephone number of the Deputy Director of North Shoa Zonal Health Bureau and were told to contact him if they had any concerns about the study.

A research assistant conducted mini interviews with potential participants to determine their ability to comprehend and express themselves well in one or both local languages for the study. During the interviews, the research assistant obtained biographic data of potential participants, the last time they gave birth and observed for women's ability to express themselves in one or both languages for the study. Grandmothers were asked about the number of children and grandchildren they had, how long they lived in their kebele and their general feelings about their communities. The research assistant observed grandmothers ability to express themselves well in one or both languages for the study. The women who met the selection criteria received affirmation to participate in the study. However, those whose language proficiency was deemed inadequate by the research assistant were not selected for the study. Working with the research assistant I purposively selected 29 women and 30 women respectively from Girar Geber and Adisge for the study. Three (3) women from Girar Geber and one (1) woman from Adisge did not show up for scheduled interviews. During the selection meetings, a research assistant read and explained consent form to participants in their local languages and asked for their feedback or concerns. With the support of a research assistant I answered all questions and concerns of participants regarding the consent form and their participation. Interview schedules were prepared with women who agreed to participate in the study. In preparing the schedules, consideration was given to local norms and practices surrounding holidays, funerals, church service, market days, christening and others (Tekola, Bull, Farsides, Newport et al, 2009). With the support of a research assistant I informed participants that they should inform the HEWs in their kebeles if they changed their mind about their participation in the study or could not attend interviews at scheduled time. Each woman

that attended the selection interview was paid honorarium of 100 birr[15] (approximately Can$6.00) for their time. Participants signed consent forms on the day of interview. All four (4) health extension workers in the study kebeles volunteered to participate in the study and were proficient in either Amharic or Oromic or both.

3.4.1.2.8. Generating the Data

The process leading up to data collection was demanding and tiring. Before commencing data collection, a research assistant reviewed the interview guides for the study for their cultural and contextual appropriateness and offered her advice. I subsequently modified the wording of the interview guides to reflect the culture, context and background of the participants and the study areas. The interview guides were translated to Amharic and Oromic languages by a woman in Fiche who holds a bachelor's degree in sociology. The interview guides were back-translated from Amharic and Oromic to English by a local English language instructor to assure their consistency (see Appendix D for English, Amharic and Oromic interview guides). The interview guides comprised semi-structured and open-ended questions designed to tap into participants' experiences and perceptions of childbirth (see Appendix D). The interview guides were pilot tested at the health posts in the study areas to determine their suitability and ability to elicit personally specific information from participants (Kivnick & Murray, 2001). The pilot interviews were transcribed to Amharic or Oromic texts and then translated to English text. This was necessary to avoid loss of nuanced meaning in transcription of participants' voices, a concept known as "interpreter bias" (Lopez, Figueroa, Connor & Maliski, 2008). Brislin (1980, 1970) advocates that interviews should be transcribed verbatim in

[15] Birr is the unit of currency in Ethiopia.

the source language (language of the participants) and then translated into target language (language for the final research output) to minimize interpreter bias. I read the transcripts of the pilot interviews and had debriefing sessions with the transcriber and a research assistant to discuss the quality of the transcripts, gaps in the interviews, what went well and what needed to improve for the next round of interviews. I incorporated the suggestions of the transcriber and the research assistant into the interview guides for refinement. Some questions were restructured and new ones were added to the interview guides. The revised interview guides were translated to Amharic and Oromic languages and back-translated to assure consistency. All research assistants and transcribers in the study were fluent in Amharic, Oromic and English.

The study used focus groups, personal interviews, fieldnotes and observational techniques for data collection. The use of multiple methods or data sources in qualitative research helps to develop a comprehensive understanding of phenomena (Patton, 1999; Carter et al, 2014). The use of multiple data sources in qualitative research is a strategy employed to achieve crystallization of information (Polsa, 2013; Carter, Bryant-Lukosius, DiCenso, Blythe et al, 2014). Crystallization is a postmodernist deconstruction of triangulation (Richardson, 2000, p. 934). While triangulation, by definition, calls for a triangle of methods that are compared against each other, crystallization refers to a myriad number of crystals that all reflect different views, dimensions, shapes, colors, patterns and arrays of the phenomenon that we study (Polsa, 2013). Thus, crystallization calls for multiple findings that lead to deeper understanding (ibid). Crystallization can lead to a multidimensional understanding of complex issues or phenomena (Tobin & Begley, 2004; Farmer, Robinson, Elliott & Eyles, 2006). Further, crystallization does not validate the data as triangulation does, but it provides room for

multiple voices to be heard and acknowledges the voices that we are unable to hear and see (Polsa, 2013). I used multiple data collection methods to gather information about intersecting personal and contextual factors that affect women's experiences and perceptions of childbirth and how they influence their birthing choices. The multiple data collection methods helped to present robust picture of the context in which women live and birth in Girar Jarso woreda. The qualitative methods included focus group discussions, in-depth interviews, observations and cultural interpretations[16]. My observations were fluid throughout the study. However, at the onset of data collection in each kebele, I conducted focus group discussions to obtain a general idea about women's experiences and perceptions of childbirth. This was followed with focused one-on-one interviews to gather more data and gain deeper insight into women's birthing context, experiences and perceptions of childbirth in their kebeles. The in-depth interviews were followed by cultural-insiders'[17] interpretations of traditional childbirth practices that emerged from participants' transcripts. Cultural interpretation was necessary for me to understand the significance of traditional birthing practices in Adisge and Girar Geber and how they might influence women's childbirth decisions. To assure dependability of the findings, the data were collected over relatively short time (4 months) to ensure consistency in data collection. Also, the data were collected from women who had given birth in the two years preceding study. In order to include a wide range of different perspectives in the research, the study explored the viewpoints of HEWs, TBAs, Grandmothers, women with home birth

[16] Elderly women considered cultural icons in Adisge and Girar Geber kebeles provided explanations to traditional birthing practices that emerged from participants' interviews.
[17] Cultural insiders are elderly women in Adisge and Girar Geber kebeles who have emic understanding of social norms and practices relevant to childbirth in their communities.

experience, women with health system birth experience and incorporated cultural interpretations of elderly women.

3.4.1.2.9. Focus group discussion

A focus group or focus group interview is a qualitative technique for data collection. A focus group interview provides a setting for relatively homogeneous group to reflect on the questions asked by the interviewer (Dilshad & Latif, 2013). This technique involves bringing a group of people together and conducting a very lightly structured interview with them around some particular focused topic (Bechhofer & Paterson, 2000 p. 67). Descombe (2007 p.115) as cited in (Dilshad & Latif, 2013) asserts that a focus group consists of a small group of people, usually between six and nine in number, who are brought together by a trained moderator to explore attitudes and perceptions, feelings and ideas about a topic. The study involved four (4) focus group discussions (FGDs) of 5-6 women each from the study kebeles. Two FGDs were conducted in each kebele of which one group comprised of women with home birth experience and the other with health system birth experience. The FGDs were conducted in locations agreed upon by participants. Table 2 depicts the number of FGDs with mothers in Adisge and Girar Geber kebeles.

Table 2: Focus group discussions

Kebele	Home birth participants	Health system birth participants	Number of discussions
Adisge	6	6	2
Girar Geber	6	5	2

The FGDs settings provided natural environment for participants to influence and be influenced by others-just as they are in real life (Casey & Kruger, 2000 p. 11). A research assistant and I arrived at the interview locations 20 to 30 minutes before the scheduled meeting time so that we could check the readiness of the discussion rooms, set up research instruments and settle before participants arrived. Also, I insisted to my research assistants that we had to arrive at interview locations before the participants as a sign of respect for them. Health extension workers in the study kebeles mobilized participants on agreed upon interview days and brought them to interview locations. After courteous exchange of greetings and introduction, the health extension workers left the interview rooms to create non-threatening space for participants to talk freely. Due to my inability to speak Amharic or Oromic languages, a research assistant moderated the FGDs while I played the role of moderator's assistant. With the support of the research assistant, I reiterated the purpose of the meeting. At the beginning of each focus group discussion, a research assistant read a consent form in Amharic or Oromic to participants and implored them to ask any questions about the study that lingered in their mind or express any concerns about their participation. With the support of a research assistant I answered all participants' questions and clarified their concerns. The research assistant informed participants of their right to answer only questions they were comfortable with or withdraw from the discussion at any time. Voluntary participation depends on accurate understanding not only of the purpose and design of a study but also of the possibility to withdraw from it at any time (Mystakidou, Panagiotou, Katsaragakis, Tsilika et al, 2009). With interpretation support from a research assistant, I informed participants that while I will protect data collected from them, I could not guarantee that other members of the focus group will do

the same. Further, I informed participants that I could not guarantee their anonymity since they were recruited from communities in which their birthing experiences may be known to other residents. However, I informed participants that I will seek to achieve anonymity by assigning them pseudonyms. All participants in the FGDs were implored to keep secret any information they were privy to in the discussions. Written consent was obtained from literate participants and oral consent was obtained from non-literate participants by a research assistant. A research assistant signed oral consent form on behalf of non-literate participants. Each participant was given a copy of the signed consent form (oral or written) by a research assistant (see Appendix E for consent forms).

At the beginning of FGDs, ground rules were set. The moderator asked permission from participants to audio-record the discussions. Participants were informed that audio-recordings will be digitally erased five (5) years after the completion of the study. Also participants were told that recordings would only be used for the stated research purposes and would be accessible to the research team and my supervisor. To increase our confidence of capturing the FGDs on tape, two audio-recorders were used at each interview. The FGDs with participants from Adisge was conducted in a conference room at Abido International Hotel in Fiche with participants' agreement. Abido International Hotel offered a comfortable and relaxed setting for group discussions. The setup allowed for circular seating arrangement. However, due to the onset of the rainy season, the FGDs with participants from Girar Geber took place at the Girar Geber Health Post as it was not convenient for them to come to Fiche. The setup at the health post did not allow for circular seating arrangement. Instead, the participants sat on a long bench facing the moderator (research assistant) and me. Each participant was given a

pseudonym to conceal their identity before the start of a discussion. The FGDs lasted 2 to 3 hours in both settings. Intermittent break in discussions was allowed to facilitate mothers to clean their babies who had nature call. The moderator used prompts and interpersonal communication skills to stimulate participants to share their experiences and perceptions of childbirth in Girar Jarso woreda. Consistent with the literature, discussions gradually moved from what appeared guarded responses to social situations where participants' interactions became spontaneous and fluid (Bechhofer & Paterson, 2000 p. 67). To avoid confusion in transcription, the moderator or I identified each discussant by their pseudonym as they began to speak. The moderator tactfully drew shy participants to the discussions with gentle smiles and direct questions. Participants were given ample time to reflect on questions and ask for clarifications when necessary. At the end of each focus group discussion (FGD) I thanked participants for their time and participation and paid their honorarium. All signed consent forms for FGD participants and audio-recorders were packed in a backpack and locked before they were transported to my hotel room in Fiche. At Waaliyaa hotel I kept all research instruments and documents in a suitcase with combination lock. The door to my hotel room was securely locked anytime I went out. Two or 3 participants from each focus group discussion were invited to participate in in-depth interviews to expand on the information they shared in the FGD. The women were chosen for one-on-one interviews based on their willingness to talk and/or richness of information they shared in the focus group discussions.

3.4.1.3.1. In-depth interview

The primary interview adopted was a mixture of semi-structured, open-ended, in-depth interview to explore women's experiences and perceptions of childbirth in Girar Jarso woreda.

The interviews began with a number of semi-structured warm-up questions intended to make the women comfortable to talk about a sensitive topic of childbirth. Following the semi-structured questions were open-ended questions, which explored in detail, women's experiences and perceptions of childbirth. The interview process opened up a space for participants to share information they would otherwise not disclose in group interview. A total of 46 in-depth interviews were conducted. Twenty-five (25) interviews were conducted in Adisge and 21 were conducted in Girar Geber kebele. In Adisge, 2 HEWs, 5 TBAs, 5 Grandmothers, 8 women with home birth experience and 5 women with health system birth experience were interviewed. In Girar Geber, 2 HEWs, 2 TBAs, 3 Grandmothers, 7 women with home birth experience and 7 women with health system birth experience were interviewed. In both Adisge and Girar Geber, the in-depth interviews followed the order stated above. Table 3 depicts the number of in-depth interviews conducted in Adisge and Girar Geber kebeles.

Table 3: In-depth Interviews

Kebele	Health extension workers	Traditional birth attendants	Grandmothers	Home birth experience	Health system birth experience
Adisge	2	5	5	8	5
Girar Geber	2	2	3	7	7

All in-depth interviews were conducted at the health posts in Adisge and Girar Geber. When participants arrived at the health posts, the research team exchanged courtesy greetings

with them and ushered them to a seat in the interview room. Before the start of in-depth interviews, a research assistant and I reviewed the ethical protocol for the study with participants. The procedure for obtaining consent from participants was essentially the same as used for FGDs (see Appendix F for ethics letter). To increase our confidence of capturing the interviews on tape, two audio-recorders were used at each interview. The in-depth interviews lasted 35 to 87 minutes. We started the interviews with semi-structured questions as warm-up and gradually transitioned to more revealing open-ended questions. The plan was that I would ask questions from the English version of the interview guides while my research assistants simultaneously read the same questions from the Amharic or Oromic guides. My research assistants found this approach frustrating and decided to direct-translate my questions without the use of the Amharic or Oromic instruments. Because I do not speak Amharic or Oromic, I relied heavily on my hunch feelings and repetition of questions as information gathering tools. In both Adisge and Girar Geber, my research assistant and I sat behind the HEWs desks and participants sat on benches facing us during interviews. This seating arrangement was chosen due to space restriction and availability of chairs. At the end of each interview I thanked participants for their time and participation and paid honorarium. All signed consent forms for participants and audio-recorders were packed in a backpack and locked before they were transported to my hotel room in Fiche.

3.4.1.3.2. Observation approach

Observational methods can involve asking questions and analyzing documents but the primary focus on observation makes it distinct from a qualitative research interview (Mays & Pope, 1995). The role of the observer, the nature of the observation data sources, systematic

recording and analysis of observations, appropriate analysis of the data and corroboration of findings are important considerations when ensuring rigor in observational methods (Coker, Ploeg & Fisher, 2013). It is argued that the main instruments for observation in qualitative study (Blommaert & Jie, 2010 p.29) are the eyes, ears, mouth and notebook. Throughout the research I used my senses of seeing and hearing as well as writing ability to gather fieldnotes. Coker et al (2013) assert that unstructured observation involves "going into the field"[18] to describe and analyze what is seen and heard. Although this study was not designed as observation study, the fieldnotes gathered through field observations added richness to the quality of overall research data. My observation approach was holistic in that it involved talking with community members, participants, research assistants and observing behaviours and study context. I adopted an inquisitive approach by asking community members, research assistants and health extension workers to explain and clarify my observations. I wrote fieldnotes during observation or immediately after in order to catch the essence of the phenomena. I observed pregnant women working long hours on farmlands, carrying huge loads or travelling long distances to Fiche on market days. While I considered myself linguistically deaf during interviews, I managed to observe the body language and inflections of participants and my research assistants. I observed participants' voices transitioned from a feeling of excitement to melancholy followed by empathic tone of voice and demeanor from my research assistants. Throughout the study most participants openly breastfed during interviews. Initially, this observation made me feel shy and uncomfortable. I expressed my feelings to a research assistant during lunch time and she responded with boisterous laughter. After she calmed herself, she asked "do you think the

[18] Going into the field refers to visiting the study areas for the purpose of data collection.

women will expose their breasts to you if they don't see you as a brother?" She continued to say "don't worry, this is Ethiopia". To avoid offending the women I did not disclose to them my feelings about the open breastfeeding. Throughout the study, I also noticed that some women sometimes avoided face-to-face contact with me during sections of their interviews. Some women directed their answers to me while others appeared comfortable engaging with my research assistants during interviews. I analyzed and reflected on my own observation fieldnotes and those of my research assistants daily to keep me grounded in the research context.

3.4.1.3.3. Cultural interpretation

A number of cultural themes emerged from the data collected in Adisge and Girar Geber kebeles. In order to gain insight into these cultural themes and their significance for childbirth, a research assistant and I sat down with four (4) and three (3) elderly women in Adisge and Girar Geber respectively for interpretation of these themes. The health extension workers in Adisge and Girar Geber approached elderly women they believed had traditional wisdom and asked them if they were interested to interpret for me. The HEWs indicated they explained the purpose and objectives of the research to the elderly women and read the content of ethical clearance certificates from University of Saskatchewan and Oromiya Health Bureau to them. The HEWs also read to the elderly women copies of support letters for my research from North Shoa Zonal Health Bureau and Girar Jarso woreda Health Administration. The HEWs arranged meetings with the elderly women for me on days and time convenient for the women. All four (4) elderly women from Adisge were interviewed on a market day in Fiche. The interviews were conducted by a research assistant and me in the assistant's office. On the interview day, with

the support of a research assistant, I thanked the elderly women for agreeing to interpret cultural themes from my research data. A research assistant and I reiterated the purpose and objectives of the study and asked the elderly women permission to audio-record their interviews. I told the elderly women that their interviews will only be used for research purposes and their names will not be captured on the recordings or mentioned to anyone in connection to the interviews. In addition, I told them that their interviews will be erased when the research is completed. As per correspondence from the University of Saskatchewan Research Ethics Board (see Appendix G), consent form was not required for the cultural interpretation. The elderly women's willingness to interpret the cultural themes constituted informed consent in and of itself. The interviews lasted 15 to 35 minutes. The cultural interpretation interviews with elderly women in Girar Geber took place in their homes. The interviews followed the same protocol as used in Adisge mentioned above. On interview days, the kebele leader on the instruction of the HEWs met me and my research assistant at the town center and took us around to show us the homes of the elderly women who agreed to interpret cultural themes for me. The kebele leader did not sit in any of the interviews. In Girar Geber, my research assistant and I waited at the entrance of the homes of the elderly women for invitation to enter. We warmly greeted the women and waited for their lead to enter their homes. As a routine protocol, with the support of the research assistant, I explained the purpose and objectives of the study and thanked the elderly women for their willingness to interpret cultural themes in my research data. The interpretations of the cultural themes are presented in chapter 4 of this dissertation.

3.4.2. Analytic method

The purpose of qualitative analysis is to interpret the data and the resulting themes to facilitate understanding of the phenomenon being studied (Sargeant, 2012). Qualitative data analysis is an ongoing, iterative process where data are systematically searched and analyzed in order to provide an illuminating description of a phenomenon (Noble & Smith, 2014; Graneheim & Lundman, 2004; Bradley, Curry & Devers, 2007). Braun & Clarke (2006) assert that qualitative data analysis is not a linear process of simply moving from one phase to the next. Instead, it is more recursive process, where movement is back and forth as needed, throughout the phases. Prior to data collection, researchers often begin analysis based on their knowledge on the topic drawn from their own discipline, reading or awareness of theory (Ziebland & McPherson, 2006) or through the conceptualization and framing of research questions. The process of analysis continues through conceptualization of research question, data collection and beyond. Therefore, the process of data analysis is fluid, and there is no clear-cut demarcation regarding when it starts and stops in the research process. Sargeant (2012) asserts that analysis ideally occurs concurrently with data collection in an iterative cycle. Sargeant posits that this allows the researcher to document the emergence of new themes and also to identify perspectives that may otherwise be overlooked. It is argued that a researcher's background, gender, biases, assumptions and subjective interpretation of qualitative data may affect the emergent construction of reality (Sword, 1999). My research questions, theoretical framework, conceptual perspective, fieldnotes and reflexivity grounded me throughout the analytical process. In order to achieve the five objectives of this study listed in chapter 1, I analyzed the data within intersectionality framework. During the analysis, I explored women's

accounts and interpretations of multiple inequalities and contextual factors that intersect to impact their birthing experiences and perceptions of childbirth in Girar Jarso woreda (Walby, Armstrong & Strid, 2012). Throughout the analysis I strove to make meaning of women's description of their social relationships in their communities, religious and cultural orientation, economic and social status, residence, infrastructure, and decision-making processes, and how these coalesced to impact their childbirth experiences and perceptions of childbirth in Girar Jarso woreda. The analytic process involved examination of transcripts, cultural icons interpretations and visual observations of study sites to gain insight into women's birthing contexts in Girar Jarso woreda. I utilized Braun & Clarke thematic analysis method for this study. The phases of this method are: familiarization with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report (Braun & Clarke, 2006). Table 4 depicts the six (6) phases of Braun and Clarke thematic analysis.

Table 4: Phases of Thematic Analysis

Phases	Description of the process
1. Familiarizing yourself with your data	Transcribing data (if necessary), reading and re-reading, the data, noting down initial ideas.
2. Generating initial codes	Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6.Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Source: Adapted from Braun & Clarke (2006, p.87)

My research questions and conceptual framework guided me in the choice of this analytic method. Although my research questions guided the analytic process, they did not directly impose pre-existing themes on the data. The inductive, thematic analytic process was driven by social constructionist epistemological perspective. Inductive analysis is data-driven coding process and does not necessarily fit into a pre-existing coding frame or the researcher's analytic preconceptions (Braun & Clarke, 2006). Social constructionist perspective espouses

that meaning and experience are socially produced and reproduced, rather than inherent within individuals (Burr, 1995). Therefore, thematic analysis conducted within a social constructionist framework does not seek to focus on motivation or individual psychologies, but instead seeks to theorize the sociocultural contexts and structural conditions that enable the individual accounts that are provided (Braun & Clarke, 2006). Framing the data analysis in social constructionist epistemology allowed me to understand women's diverse construction of their experiences and perceptions of childbirth in Girar Jarso woreda. The social constructionist framing illuminated how women's socio-economic position, education, residence, power status, religion, health system characteristics and community attributes intersected to influence how women perceived childbirth in Girar Jarso woreda. Further, analyzing the study data within social constructionist epistemology provided insight into why some participants who had similar childbirth experiences expressed different opinions about childbirth in Girar Jarso woreda. The analysis revealed that women's social construction of childbirth influenced their decisions about place of birth and choice of birth attendant (Rothman, 1977). For example, in this study, women's construction of labor influenced their decisions about when to seek help. The choice of thematic analysis for this study was influenced by the method's ability to directly represent the descriptions of respondents' viewpoints, experiences, beliefs and perceptions (Luborsky, 1994).

I conducted initial data analysis while in the field to determine emerging themes. I wrote summary notes on the emerging themes and my interpretations and discussed them with my research assistants to seek their opinions on them. At a coffee ceremony in Fiche, following data collection and early phase of analysis, I presented the preliminary findings to

study participants for confirmation. Upon returning to Saskatoon (Canada), I collated interview transcripts, fieldnotes and cultural interpretations according to participant groups and study area for further analysis. Compartmentalizing data into manageable chunks can relieve researchers of the feeling of drowning in data (Seers, 2012). Due to logistical constraint I could not involve my research assistants in the second wave of data analysis and interpretations. Tsai et al (2004) noted that when researchers are unable to check the translation accuracy, they should include an individual who understands the language and culture in the analysis process. During the preliminary analysis in Ethiopia, a research assistant peer-reviewed transcripts to ensure their consistency with their audio versions. Guided by Bradley et al (2007) immersion strategy, I proceeded to read the entire text without coding or writing memos. I devoted the second reading of the text to detecting and highlighting inconsistencies and removing typographical errors to clean the data. Subsequently, I re-read the data line by line several times (Graneheim & Lundman, 2004; Broom, 2005) to obtain a sense of the whole, wrote margin notes, memos and initial codes. I highlighted rich or significant words, quotes or passages in the data to inform the coding process. Braun & Clarke (2006) assert that reading and re-reading provides the bedrock for data analysis. Coding moved through a process of development and refinement throughout the analysis. Some codes eventually became embedded in multiple categories due to their underlying concepts. For example, the code `trust' appeared in the categories privacy and confidentiality, compassionate care and health system characteristics. The manual coding approach I adopted allowed me to immerse in the data in a way that I felt I had become part of the data. I created a coding tracker which allowed me to organize the codes, and was useful when I categorized the codes. I consolidated related

codes into sub-themes or categories which were later merged to create themes based on commonality in their manifest content (Graneheim & Lundman, 2004). Themes are abstract concepts, reflecting interpretation of patterns across data (Seers, 2012), so from codes, categories can be formed, and from categories, more encompassing themes are developed to describe the data in a form which summarizes it, yet retains the richness, depth and context of the original data. This abstraction allowed me to group data together under higher order headings for descriptions and interpretations on a higher logical level (ibid). I employed latent content analysis process of interpretation to discover underlying contextual meanings of the words in participants' transcripts (Hsieh & Shannon, 2005). Figure 3-2 depicts a flow chart utilized for data coding and analysis in this study.

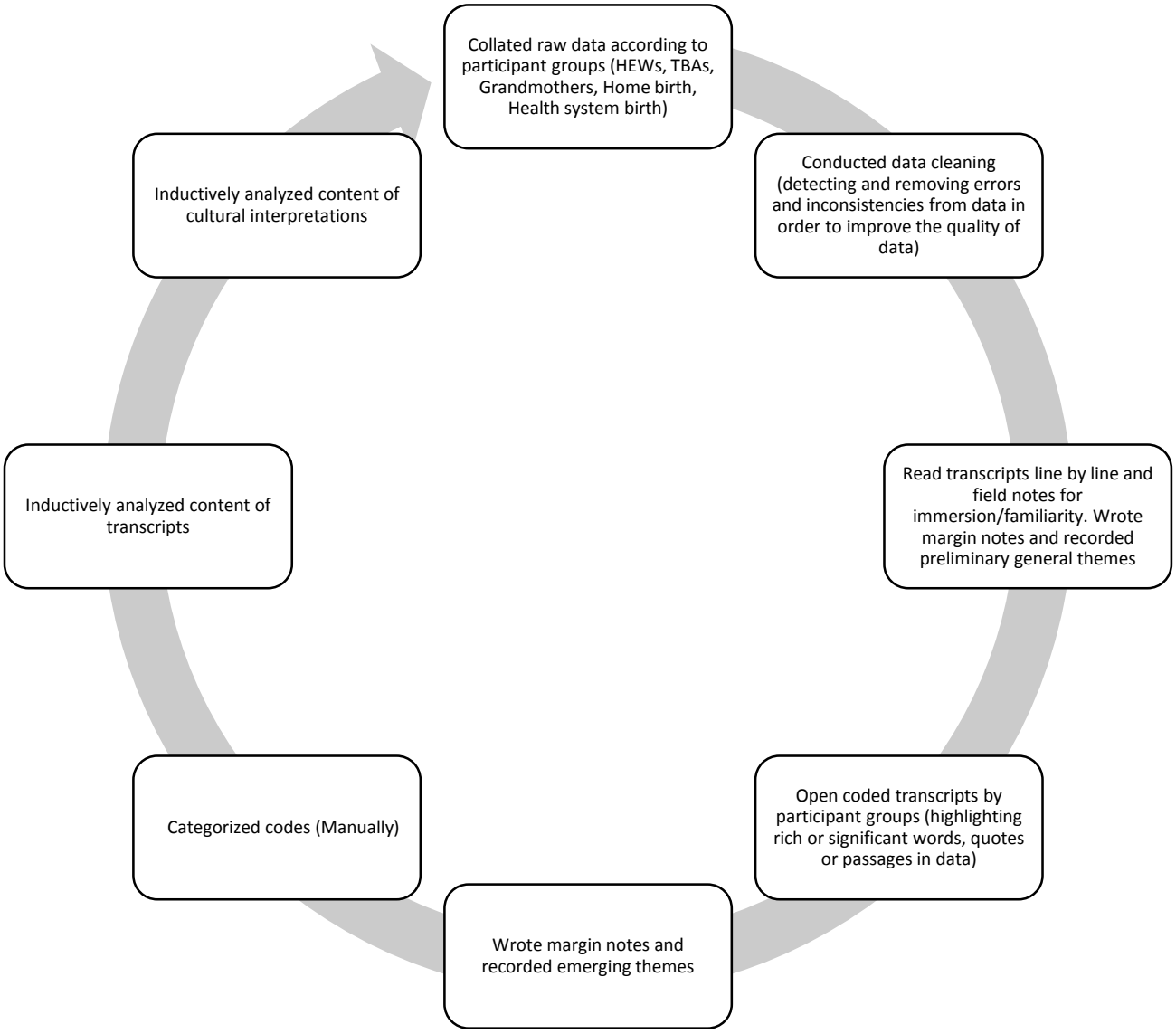

Figure 3-2: Flow Chart for Data Coding and Analysis.
Source: Adapted from Braun & Clarke, 2006 p.87

Through iterative, back and forth process, I sought manifest content of the data throughout the analysis. By focusing on the manifest content of data, my interpretations were influenced by participants' voices and my conclusions reflected what participants' considered their reality. Throughout the inductive analysis, I looked for similarities, differences and

contradictions in participants' stories and accounts of their experiences (Braun & Clarke, 2006; Broom, 2005). For example, I paid attention to women's different reasons for birthing at home, within health system, with traditional birth attendants, friends or family members. Further, I explored women's similar and diverse sentiments about their birthing experiences and contexts in Girar Jarso woreda. When I completed the data analysis for each participant group in each kebele, I conducted cross-kebele comparison of concepts in each participant group to determine commonalities or differences in emerging themes (Bradley, Curry & Devers, 2007). I found women's expression of their childbirth stories, birthing contexts and perceptions of childbirth in the two study kebeles to be relatively similar. In addition, data revealed that cultural differences between the two study communities are minor. As a result, more specific data were grouped together for a unified and comprehensive analysis and interpretation. I reviewed the combined interview transcripts, fieldnotes and cultural interpretations to refine codes and code structure until the point of saturation (Glaser, 1992; Patton, 2002), a point at which no new concepts emerged from reviewing successive data from participants. I utilized inductive thematic analysis adapted from Braun and Clarke (2006) to make sense of and understand the data. The interpretation involved comparing data codes and categories within and across transcripts and across variables deemed important to the study (e.g. choice of place of birth and birth attendant, perception of health professionals' attitude). At the end of the inductive analytic process, overarching themes emerged. These themes are presented in the findings section of my dissertation as headings and sub-headings. While I made concerted effort to represent the "true voices"[19] of participants across themes and interpretations, it is

[19] True voices refers to unaltered representation of study participants' voices.

possible that some of these voices were lost in translation as interviews were transcribed from audio to the local languages before they were translated to English.

3.4.3. Quality assurance

The intent of qualitative research is to contribute to understanding. Hence, the research procedures for selecting participants, analyzing data and ensuring research rigor differ from those for quantitative research (Sargeant, 2012). Assessing "quality" in qualitative research faces wide epistemological debate (Mays & Pope, 2000). Mays & Pope (2000) assert that the issue of "quality" in qualitative research is part of a much larger and contested debate about the nature of the knowledge produced by qualitative research, whether its quality can legitimately be judged and if so, how. Notwithstanding this epistemological challenge, many qualitative researchers believe that authenticity of data and trustworthiness of data analysis can be useful strategies for assessing the quality of qualitative research (Patton, 2002; Kuper, Lingard & Levinson, 2008). Authenticity of the data refers to the quality of the data and data collection procedures, whereas trustworthiness of the analysis refers to the quality of data analysis (Sargeant, 2012). The key elements of authenticity include sampling and participant selection, data crystallization, appropriateness of data collection methods, issues of consent, beliefs and biases of data collectors. Similarly, the key elements of trustworthiness are credibility, dependability and transferability.

3.4.3.1. Authenticity of data

The study topic went through a process of editing and refinement to ensure acceptable focus. The topic transitioned from a broad focus on maternal health services and referral system to women's experiences and perceptions of childbirth in Girar Jarso woreda. The study

areas were chosen through stratification and random selection to avoid selection bias. Participants were purposively selected and the process was guided by strict inclusion and exclusion criteria. The study used multiple methods of data collection to ensure rigor. Although this study did not aim for convergence of data, I compared findings from the multiple data sources and looked for patterns of similarities and differences of participants' stories that shed light on women's collective and individual experiences and perceptions of childbirth in Girar Jarso woreda (Tobin & Begley, 2004). The methods used were focus group discussions, in-depth interviews, observation and fieldnotes. The use of multiple data sources produced a comprehensive view of women's experiences and perceptions of childbirth in the study areas (Sargeant, 2012). Interview guides comprised of warm up questions and open-ended questions in study content area that allowed women to share their childbirth experiences and perceptions. My biases and preconceptions about childbirth were minimized in the study as research assistants (neutral third parties) moderated focus group discussions and led in-depth interviews. Also, I attempted to minimize the impact of my preconceptions on the study by engaging in "internal dialogue" (reflexivity)[20] to understand what I knew, what my experiences were and how they influenced my thought process during field observation (Freysteinson, Lewis, Sisk, Wuest et al, 2013). I used a reflective audit trail to capture the decisions I made from the study design through data collection to data analysis.

A reflective audit trail is essential in bracketing one's views from the phenomenon under study as a way of controlling bias and improving methodological rigor (Gilgun, 2008; Tufford &

[20] Reflexivity is the process of examining both oneself as researcher, and the research relationship. It involves examining one's conceptual baggage, one's assumptions and preconceptions, and how these affect research decisions, particularly, the selection and wording of questions.

Newman, 2012; Jootun, McGhee & Marland, 2009; Bishop & Shepherd, 2011). Further, to ensure that my gender and background did not interfere with data collection, after obtaining consent from three (3) women who had previously participated in FGDs with me, I asked my main research assistant to conduct one-on-one (in-depth) interviews with them to determine if my presence interfered with the women's willingness to disclose their childbirth experiences. Those interviews were transcribed, analyzed and discussed in a debriefing session. When the transcripts were compared with what the women said in FGDs and what other women said, the research team concluded my presence did not appear to influence what women said in interviews. Throughout the study, I relied on my hunch feelings and repetition technique to ensure that my research assistants did not miss important questions on interview guides or follow-up questions. All subjects agreed to participate in the study without coercion or inducement.

3.4.3.2. Trustworthiness of the data analysis

To increase my confidence in the data analysis and to assure that analytic process was congruent with study focus, I used the research questions and conceptual framework as guides throughout the analysis. The study used informant accounts to support participants' stories to assure trustworthiness of findings (Endacott, 2005). I looked for contradictions within individual participant's stories and across participant groups. Also, I searched for negative cases or accounts that deviated from the dominant stories and discussed them (Mays & Pope, 2000). I ensured that categories and themes covered all important data, no important data were left out and no external data were included in the categories and themes. Throughout the analytic process I endeavored to suppress my beliefs, experiences with childbirth and preconceptions

(Endacott, 2005). I recognized while it was not possible for me to completely rid myself of my experiences and perceptions of childbirth, the constant reflection on how they could impact the research provided the level of awareness that I needed to minimize subjectivity throughout the research. Also, to assure trustworthiness, I presented the study findings to participants for confirmation. Because majority of the participants were non-literate, I presented the study findings orally to the entire group (to avoid differential treatment) at a coffee ceremony for validation (Mays & Pope, 2000). In addition, my research assistants and a transcriber peer reviewed the data and findings at debriefing sessions to assure quality. Peer debriefing contributes to confirming that the findings and the interpretations are worthy, honest and believable (Spall, 1998). I used representative quotations throughout the report to judge the similarities within and differences between categories and across participant groups.

3.5. Ethical consideration

This research was conducted with approval from University of Saskatchewan's Behavioral Research Ethics Board and Oromiya Health Bureau in Ethiopia. Participants had the opportunity to read the consent form or had it read and explained to them before they signed it or gave oral consent. The participant recruitment process was without coercion or inducement. The research was rated low risk as all the participants were adults and had consented to participate in the study willingly. Interviews and focus group discussions were conducted in non-threatening atmosphere in locations participants agreed on. Research assistants and transcriber/translator agreed to maintain confidentiality. All participants signed transcript review waiver form as some participants could not read or write (see Appendix H).

The transcriber signed confidentiality agreement form to re-affirm his commitment to confidentiality beyond the research period (see Appendix I).

3.6. Limitations and Delimitations

The research was beset by a number of limitations. The main limitation relates to the fact that I was cultural outsider with no knowledge of the *defacto* inquiry languages (Amharic and Oromic). I took steps to address the linguistic barrier by recruiting two research assistants and transcriber/translator. However, this could have caused limitation in the research process as research assistants and transcriber might have edited interview questions or participants' responses respectively. Due to my illiteracy in Amharic and Oromic, I was not able to check transcripts back against their audio-recorded versions (interviews) to assure consistency. In addition, my gender and background as African-Canadian graduate student might have subconsciously influenced what women said in interviews and focus group discussions. Almost all the women interviewed were farmers and non-literate, and may have experienced childbirth differently from educated women in their communities. In addition to the above limitations, the research had a number of delimitations mentioned below. The research was restricted to two rural kebeles in Girar Jarso woreda. Therefore, the information gathered about women's experiences and perceptions of childbirth may not apply to women in other parts of Girar Jarso woreda or Ethiopia. Another delimitation of the research was that it did not explore the perspectives of men, teenage mothers and health professionals (other than HEWs) about childbirth. Further, the study was not action research, rather, it was exploratory case study. Therefore, the research recommendations may or may not be implemented.

3.7. Lessons learned

As a novice researcher, I have learned the process of global health research through the expert guidance of my doctoral program supervisor. From topic conceptualization through data collection to report writing, I have learned the virtues in patience, trust, self-confidence and the importance of networking in regards to research. I have become aware of the difficulties in conducting research in foreign languages and foreign cultures. I learned how to develop trust and confidence in my research team in order to delegate control over the interviews, focus group discussions and transcription to them. Although, I initially felt sidelined, powerless and not in control of the data collection process, I eventually became comfortable with my decisions. I painstakingly learned how to work with research team-members who had different time orientation and value system. I learned how to bottle-up my frustration and engage with research assistants, transcribers and translators when they did not meet my expectations. The research experience aroused my creativity as I was able to come up with strategies to assure data quality throughout the fieldwork. The use of hunches and repetition during interviews, debriefing, language proficiency screening, peer checks and balances, reflexivity and allowing a research assistant to conduct three (3) interviews without me to ascertain whether or not my presence had impact on the quality of data collected were some of the strategies I developed in response to the research context. Also, I learned about the power of networking and partnerships in global health research. Most importantly, I learned that I increased my acceptance in the research sites by adapting to the cultures of the host communities, socializing in culturally-appropriate ways, maintaining humility and respect for community residents.

3.8. Conclusion

In this chapter, I have clearly explained the theory and conceptual framework underpinning my research and how I incorporated them in the data analysis. I have clearly articulated the decisions I made concerning research design, sites and participants selection, sample size, data collection, coding and analytic methods as well as data interpretation. I have also mentioned in this chapter the challenges and lessons I learned in the research sites, strategies I used to navigate challenges and steps I took to fit into the host cultures. Also, in this chapter, I have described the limitations and delimitations of this research and their implications for study findings and their generalizability. Further, in this chapter, I have presented steps that I took to assure data quality and adherence to ethical guidelines throughout the study.

Chapter 4: Findings

4.1. Introduction

In this chapter I provide the findings of my case study which explored women's experiences and perceptions of childbirth in Girar Jarso woreda of Ethiopia. The chapter provides succinct description of the context in which women live and birth in two study areas in Girar Jarso woreda. In addition, in this chapter, I provide quotations of women regarding the contextual factors which influence their choices of place of birth and/or birth attendants in Adisge and Girar Geber, the two kebeles chosen for this study. The chapter presents what women in the study areas value about home birth as well as what motivates women to engage with health system during childbirth. In addition, I present in this chapter interpretations of cultural childbirth practices revealed in participants' interviews. Chapter 4 is a summary of data collected in the two study areas through in-depth interviews, focus group discussions, observations and cultural interpretations. During the interviews women answered a wide range of questions that allowed me to capture the multiple intersecting contextual factors relevant to their birthing experiences and perceptions of childbirth in Girar Jarso woreda. While the in-depth interviews allowed women to express their individual experiences and perceptions of childbirth, the FGDs provided a forum for women to share in each other's birthing experiences and discuss contextual influences on childbirth in Girar Jarso woreda. The findings presented in this chapter capture the broader experiences and perceptions of key informants (HEWs, TBAs, grandmothers) as well as women who birthed at home or in the health system. I conclude this chapter with my reflections on data collected from this study.

4.2. The context of birthing in Girar Jarso woreda

Birthing in the mountains and valleys of Girar Jarso woreda of Ethiopia poses unique challenges for women and their families. The pain of despair, hopelessness and anguish engulfs a whole community during childbirth. Stories of agony, bleeding, retained placenta, tangling, road side birth and deaths are prevalent in this study. On the other hand, this study is not short of stories of joy, celebrations and pride. Girar Jarso woreda, the nucleus of this study is a poor rural farming community in central Ethiopia. The woreda is about 125 kilometers north of Addis Ababa, the national capital. The terrain is mountainous with picturesque valleys. The area experiences rainy and dry seasons. Because of the terrain and road condition, vehicular transportation to certain villages in the woreda become problematic in the rainy season. There is one arterial road that crosses the woreda from Addis Ababa to Bahir Dar. Bahir Dar is a cosmopolitan city north of Girar Jarso woreda. All feeder roads connecting the arterial road are without asphalt. The main cash crops grown by residents of the woreda are wheat, turf, beans, maize and sorghum. Girar Jarso woreda is popular for livestock production. The main livestock reared in the woreda are cattle, sheep, goats, donkeys and horses. Donkeys and horses are used mainly for intra woreda transportation. Many woreda residents use cattle to plough their lands for crop production. Most people living in Girar Jarso woreda commute by walking. Interviews with women revealed that the people in the study areas embrace collectivist decision-making rooted in tradition. The women expressed that childbirth in their societies is a community affair. As a result, pregnant women usually consult their families, neighbors and other community members in decisions about where they birth or who attends to their childbirth. Community members may attend childbirth invited or uninvited. Childbirth has

galvanizing effect in Adisge and Girar Geber societies as it brings people together around a common interest. During childbirth, community residents gather at the laboring woman's house in prayer and servitude. Childbirth is also a time for reconciliation. When a woman experiences prolonged or complicated labor, community members who have feud with her are supposed to proclaim their forgiveness to relieve the woman of pain, discomfort or danger. Intrapartum food service, coffee ceremonies, celebrations, mourning and postpartum care are rituals associated with childbirth in the study areas. Apart from their socio-cultural context, women in the study kebeles opined that their childbirth experiences and perceptions are influenced by other contextual factors. Topography, availability of transportation, distance to health facilities, personal and biological factors have contextual influences on childbirth. During the data coding, categorizing and theme creation phases of this study, I carefully highlighted women's stories of how the above-mentioned contextual factors intersect to impact their birthing experiences and perceptions of childbirth in Girar Jarso woreda. Using intersectionality lens, I aligned participants' stories and birthing accounts with the research questions for this study in order to tease apart the contextual factors that influence women's choice of place of birth and/or birth attendant, what women value about home birth and women's motivations to engage with health system during childbirth.

4.2.1. Contextual influences on women's choice of place of birth and/or birth attendant

The study revealed that numerous factors influence women's choice of place of birth and birth attendant in Adisge and Girar Geber kebeles of Ethiopia. According to participants the intersecting contextual factors influencing women's birthing decisions in the study kebeles are

socio-cultural, knowledge and education, economic, biological, environmental, and structural in nature.

4.2.1.1. Socio-cultural context

4.2.1.1.1. Decision-making process

Childbirth decisions in Adisge and Girar Geber occur in cultural context with involvement of many stakeholders. The decision-making takes place at the individual, family and community levels. Due to the social structures of Adisge and Girar Geber, the community can override the decision of a laboring mother or her husband. Generally, this complex hierarchical social decision-making process undermines the self-determination of laboring women. Albeit, the community usually overrides decisions made at lower levels of social structures to protect the interest of the laboring mother. The underlying principle is that the pregnant mother usually makes childbirth decisions in consultation with others or the decisions are imposed on her. Women in the study overwhelmingly expressed that their birthing decisions are made within socio-cultural context with the involvement of family and community. Most women object to this traditional decision-making process and seek autonomy over their childbirth decisions. This wish goes counter to established traditional norms and sometimes creates tension between laboring women and society. While a few women in the study made unilateral decisions about their childbirth, most women made childbirth decisions in consultation with their husbands, health professionals, traditional birth attendants and families or other community members. A few women described the delays collective decision-making process caused to their access to professional care in health institutions during childbirth. Women appear to have limited decision-making power in the study areas as their decisions are easily over-turned by families or neighbors. Mothers-in-law, traditional birth

attendants and health professionals are community members with most childbirth decision-making power in the study areas. The following statements reflect the complexity of childbirth decisions and choices described by women.

> *The priority to the decision-making is taken by neighbors (us). We would not let the woman be tortured. So the husband would decide next to us. If the woman refused to go to hospital her right may not be protected. Because we could force the woman to go to hospital regardless of her refusal (Anneka: grandmother, Adisge).*

> *We the older women would like our daughters and grand-daughters to be helped by the health professional during childbirth. So all the family members-mothers, sisters and her husband and she could decide the professional to be helped by (Tanisha: grandmother, Adisge).*

A woman with both home and health system birth experiences lamented as follows:

> *I talked with my parents. I talked with my husband. I have talked with health extension workers. In the past I [had] no awareness about birthing experience in hospital or health center. That was why I gave birth at home without visiting the doctor. I conferred with my friends and family members. They all said I should give birth in Ginno Health Center or hospital. They said I shouldn't give birth at home…this is very crucial to avoid [what] could come from birthing complication at home. The elderly mothers also advised me that I shouldn't be hurt as so was in their time. They said they suffered from birthing complications. Everybody told me to give birth in health center (Tiffany: Girar Geber).*

Other women described their childbirth decision-making processes as follows:

I was talking with my neighbors and with my husband. I talked with these people that I would choose to give birth in hospital. I would talk with customers and with my mother (Victoria: Girar Geber).

My mother-in-law told me that I should go to the health center first for medical examination and secondly for childbirth. She told me seriously that I shouldn't give [birth] as before (Alberta: Girar Geber).

Though we decided where and how to birth with my husband, my uncle took me to his house to take care of me. When I was in labor my uncle summoned all the neighbors. I knew nothing about it. All the decisions were made by my uncle. He called the traditional birth attendants but they were of no use somehow (Hannah: Adisge).

During an in-depth interview a woman expressed how her community over-turned her parents' decision to send her to hospital during childbirth.

My mother and father wanted me to give birth in the hospital. But the villagers forced us to stay for a while (Beatrice: Adisge).

In spite of the complex decision-making process; some women are able to assert themselves in the choice of place of birth and birth attendants. The following quotations illustrate women's autonomy in their childbirth decisions.

It was me who decided where to give birth. I decided that if the labor would come shortly I would give birth at home if not I decided to go to hospital. This was what I thought during the pregnancy periods. Since it is lowland area (the village we live in), it hampers

birthing in hospital. We would manage our way to hospital when the labor gets severe (Erica: Adisge).

No one forced me to choose the place where I should give birth. No one recommended the place I should give birth. I had no pressure from behind (Maxine: Girar Geber).

No one forced me to choose the place where [I] should give birth. But some of them said it is Mary [St. Mary] who could help the child birth regardless of its place. They [said] it doesn't matter whether it is at home or in the health center. So they persuaded me to give birth at home. I told my husband to take me to hospital rather than regretting after the child birth at home (Carla: Girar Geber).

I will choose to give birth at my home. But if the labor stays longer than a day or two I will go to the hospital (Patricia: Adisge).

Traditional and religious beliefs

The traditional and religious beliefs of women and their social networks was found to influence choice of place of birth and/or birth attendants. Many women rely on their faith in God and Saint Mary during childbirth. These women believe in spiritual intervention in the choice of place of birth, birth attendant and outcome of childbirth. Consequently, women's faith in the divine and attachment to traditional childbirth practices were found to exert tremendous influence on where they birth or who attends to their childbirth. Some women in the study areas believe that God and/or Saint Mary decides the place of childbirth. As a result, women with these beliefs do not choose where they birth their children. Instead, they trusted

in divine intervention for the choice of the place of their childbirth. Most women with strong traditional and religious beliefs wind up birthing at home. Occasionally, traditional women birthed in the health system due to childbirth complications. Women expressed their faith in the divine as follows:

> *By the time I am in labor mother Mary would come and [help] me. No one decides for me where to give birth. It is only God decides (Amanda: grandmother, Girar Geber).*

> *When it is my month and mother Mary (mother of Jesus Christ) get nearer to me I give birth. The previous was very dangerous, mother Mary did not get nearer to me easily. The feeling was very intense (Jennifer: Adisge).*

> *It was God's choice and will for me to give birth at home. They were telling I could use the ambulance to give birth in the health center or hospital (Tamara: Girar Geber).*

> *If the case appeared dangerous to give birth at home they would take the mother to hospital. But in my case God is so kind for me. I give birth easily at home. If God allows me to give birth at home I will give birth at home. There wouldn't be stress (torture) then I would give birth without complications (Portia: Girar Geber).*

A few participants stated that women with religious beliefs are of the view that the place of birth has no significance for birth outcome.

> *Some of them [women] who believe would say that it is all about St. Mary's will and permission to have a peaceful child birth regardless of its place (Rosina: Girar Geber).*

The outcome of our life depends on God's will including childbirth (Patricia: Adisge).

Some women hold on to cultural norms that prohibit them from birthing outside their homes. These norms limit women's childbirth choices and often consign them to birth at home.

There is a cultural belief that prohibits the birthing woman to go outside their house. They would not want their placenta to be dropped outside their house. There is a fear about that (Sasha: HEW, Girar Geber).

In Adisge there is a parallel belief that women should birth their first child in their parents' home.

My first child was born at my parents' home. The labor started after sunset. I was done with birthing before it was dawn. In our culture the first baby is supposed to be born in your parents' home (Patricia: Adisge).

On the other hand, women in Girar Geber believe that they should continue to birth the same place their first child was born.

There is a belief that women should give birth where the first child was born (Sasha: HEW, Girar Geber).

Yet, some women follow family tradition of home birth and steer clear from health facilities during childbirth.

Some women follow family tradition of home birth. Those women did not accept our teaching. They will say "my mother gave birth at home but nothing bad happened to her". These women are afraid of health professionals. They will say "I am going to a strange health professional and these professionals may insult me since I am from rural

lowland (kola)". This is inside them. They feel inferior. They don't want to be discredited (diminished) in front of health professionals so they hide themselves and birth at home (Sandra: HEW, Adisge).

In spite of the preponderance of home birth, some women birth in health facilities mainly due to health education, previous birth experiences (self or others), birthing complications and other factors. These facilitators for health system birth are further elucidated later in this report.

Family responsibilities

Women in Adisge and Girar Geber participate in household work and farming activities up until the time of childbirth. This social contract is temporarily broken for forty or eighty days after childbirth depending on the sex of the newborn. Women in Adisge and Girar Geber usually take respite for forty days after giving birth to a boy and eighty days for a girl. During the rest period the new mother is exempted from household duties and farm work. The new mother is cared for by family, friends and neighbors and she is advised to stay in doors to avoid cold wind or sunlight. The new mother resumes her normal duties after her baby is baptized at day 40 or day 80 (boy or girl respectively). Many women in the study expressed that their family responsibilities play crucial role in the choice of place of childbirth. Many women birthed at home because of their concerns about household and farming needs. Those women refused to birth in the health system because of the importance they attached to family and cattle needs as well as their crops. The following excerpts from interviews illustrate women's concerns.

Yes I chose to give birth at home. They taught us to give birth in health center or hospital. I do believe it is safer to give birth in the hospital. However, we would benefit if

we give birth at home. I thought going away for days or weeks to give birth would disrupt my home or life. I thought it would freeze my life in my home. I thought of my children that no one would take care of them like I would do. For the house work and for the care of my children I would like to give birth at home (Shamette: Girar Geber).

It was my own decision. I decided to birth at home. First of all our village is very far from the hospital. Secondly, if I set up things to dwell in town till the child birth no one would look after my children, home, husband and the cattle. No one would look after our possessions (Cynthia: Adisge).

4.2.1.2. Knowledge and education context

Women's childbirth decisions are evolving in the study areas. Overwhelming majority of women suggested their choice of place of birth or birth attendants is influenced by their awareness. Generally, it was believed that non-literate and unexposed women are likely to birth at home due to their traditional beliefs and lack of awareness. Contrary, there was a perception amongst participants that enlightened women embrace health education and birth in the health system. A number of women who birthed at home cited their level of education or awareness as a major factor that influenced their childbirth decisions. Most women in the study expressed that they became inclined to birth in health facilities as their knowledge about the benefits of health system birth increased. Below are excerpts which illuminate participants' perspectives.

Most women in our village would like to give birth in health center. They have already identified the pros and cons of birthing in hospital and home. If their village is not

accessible by ambulance, they prepare traditional ambulance to take birthing women until the point where the [conventional] ambulance is available to take over (Joana: Girar Geber).

It was not because of the hostility about the childbirth experiences in hospital. Rather it was our backwardness and illiteracy that forced us to give birth at home (Maxine: Girar Geber).

I was bleeding hard. My mind was not in a normal condition. I felt as if my brain was split in two. It was all because of our backwardness and illiteracy. It wouldn't be same if I gave birth in hospital. What if I told them to take me to hospital? (Rochelle: Girar Geber).

Some [women] easily would think that she gave birth at home previously. So she would conclude to give birth at home. This is because of her backwardness or illiteracy. It is because they lacked education. There is nothing else. It is all about lack of awareness and education (Anneka: grandmother, Adisge).

To buttress this point, a traditional birth attendant articulated her thought as follows.

Some of them [women] would think that they would be charged money. Some of them would not know the support in hospital. They said they would not know what would be done to them in hospital (Nadia: TBA, Adisge).

A grandmother expressed her discontent with home birth and cited lack of awareness as a reason for many women in her community to choose home birth over health system birth. Below is an excerpt from her transcript.

> *It is because of lack of awareness. I wonder about the women who are giving birth at home. I think they have lost their mind. They should not overlook the education about the childbirth experiences in hospital. I would never choose women to give birth at home (Stacy: grandmother, Girar Geber).*

4.2.1.3. Economic context

The economic status of the birthing mother and her family features prominently in the decision about choice of place of birth and birth attendant in the study areas. In the event conventional ambulance services were not forthcoming, women relied on family savings, loans or community funds for emergency referral to health facilities during childbirth. These precarious sources of funding offered no guarantee to birthing women and their families. Mobilizing funds in the midst of obstetric emergencies can engender anxiety and pose real threat to survival of laboring mother and her unborn child. Against this background, some women are constrained by lack of financial resources to birth at home. On the other hand, women with adequate financial resources were likely to birth in the health system.

> *Birthing at home saves the mother from expending money, inviting men who may carry her to hospital with traditional alcohol or buying lunch for those who carried her to health center or hospital. There are women who say no matter how much it will cost I have to save my life and the life of my child (Sandra: HEW, Adisge).*

A quotation of a grandmother adds to the financial constraint discourse as follows.

The husbands were likely [preferred] that their women would give birth at home. Rather than to incur (expend) costs in hospital so they were not volunteer [willing] to take their birthing women to health center/hospital (Tanisha: grandmother, Adisge).

Financial constraint appeared to be a generational challenge for birthing women in Girar Jarso woreda as a grandmother from Adisge retorted poverty prevented her from birthing in the health system.

I said my poverty. I am too poor to go here and there [to birth] (Grace: grandmother, Adisge).

Similarly, a grandmother in Girar Geber recounted the ordeal of women her age in their community during childbirth due to financial constraint and inability to access health system.

In the past we were ashamed of getting pregnant. Then we were scared of going to health center or hospital. The men were not volunteer (willing) to take their birthing women to hospital. They had also concern of money to take the [women] to hospital during the childbirth. There was no free service for birthing women in hospital. Birthing women used to labor for days [at home] because of money problem. The husband would not expend money for the childbirth. So the birthing woman would stay in labor for two or three days. Amid these days the baby could die from birthing complications (Abigail: grandmother, Girar Geber).

4.2.1.4. Biological context

The time of onset and duration of labor was frequently cited by women as the reasons for their home birth. A number of women indicated they birthed at home because their labor did not last long enough for them to access health facilities. Other women asserted that they

could not seek professional care because their labor started late in the night. Generally, women in this study believe that duration and time of onset of labor play significant role in the choice of locations women birth and who attends their childbirth. Some participants believe that the pace of labor may prevent women from reaching health facilities before their birth. As a result, women who had intention to birth in the health system wound up birthing at home or on their way to health institutions. Similarly, some participants opined that women who experience onset of labor at night may find it difficult to access health institutions due to poor visibility, bad road condition or lack of access to transportation. Most women birth at home if they experience short labor with onset at night. However, women would seek professional help at night if they encounter birthing complications. A health extension worker opined as follows:

> *First, the nature of labor pains is of different types. Some women would labor and give birth immediately. These women would not go to the hospital to give birth (Sasha: HEW, Girar Geber).*

Similar points were raised by traditional birth attendants in Adisge and Girar Geber.

> *Those women whose labour would end fast (whose labour ends quickly), would give birth at home (Monica: TBA, Adisge).*

> *We would take birthing women to hospital who labor stays for longer time. For those birthing women whose labor go fast would give birth here at home (Betina: TBA, Girar Geber).*

Other women expressed related experiences or perceptions as follows:

I gave birth at home in Adisge. My labor did not last long. My first child's birth was not hard. I was just baking enjera, cooking stew. Then finally the labor started. I gave birth shortly. It did not give me enough time to go to the hospital. For the second child, labor was fast as well (Linda: Adisge).

If it [labor] came in the late night, I would go to hospital when it got dawn. What if I dwell in town I could go to hospital anytime I want to. So the labour hour is decisive (Hannah: Adisge).

Another woman expressed parallel sentiment to Hannah's as follows:

I started to bleed from beneath. When the pain got severe my mother-in-law was called. She noticed that I was bleeding. It was longer than the previous childbirths. It was very strange because it had no movement, besides the blood oozed (poured) before the childbirth. And this was not a good sign. Then they let me stand up. It was at this time the dead [baby] came out while I was standing leaning on them. Since it was midnight we could not go to the hospital (Patricia: Adisge).

A number of women in the study claimed they intended to birth in the health system. However, they ended up birthing at home against their desire due to precipitous labor. The following quotations illustrate women's experiences.

I thought I should give birth in hospital. I told this to my husband, family members and neighbors. I told them with its benefits of hospital birthing experiences. They were all in agreement with me. My plan was to give birth in hospital. They confirmed for me that as an educated person I should give birth in hospital. The doctors were also warning me not

to stay far away from the hospital. I was there in hospital two weeks from the child birth. He [health professional] told me to stay in Fitche town or around. But as a matter of chance I gave birth at home. On the day I gave birth I had an appointment for the follow up of the pregnancy (Brenda: Girar Geber).

The reason why I conferred with my family and husband to give birth in the health center was just to avoid the potential problems I could suffer from during childbirth. But the labor didn't last long. I gave birth after they called the ambulance (Tamara: Girar Geber).

A similar reason for birthing at home was expressed by a focus group discussant as follows:

Ayi …If my labor pains were bad, I would go to hospital. It came urgently. If it would have stayed, I would like to give birth at hospital. I had the desire. But it did not stay long. I gave birth at home without my consent (Andrea: Adisge).

4.2.1.5. Environmental context

Road condition, distance and access to transportation influenced decisions about choice of place of birth and birth attendant in the study kebeles. Geographical location, rough terrain, weather conditions and unreliable vehicular service to communities hinder birthing women's access to health institutions. These conditions operating in tandem complicate the birthing context and limit women's birthing decisions and choices as explained by participants. Figure 4-1 depicts a section of the winding road linking Adisge kebele to Fiche.

Figure 4-1: A section of the road linking Adisge to Fiche.
[Photograph], by Tefera, A, 2014.

Many women in Adisge elaborated the logistical difficulties they faced when they birthed in health facilities. Some women walked or were carried on traditional stretcher[21] to health facilities where they birthed. Others used a combination of taxi (bajaj)[22] and walking to access health facilities when in labor. A woman in Adisge walked back home from Fiche (20 kilometers journey) after she birthed at Fiche Zonal Hospital. Similar logistical challenges were encountered by women in Girar Geber who ventured to birth in the health system. Some women in Girar Geber recalled their experiences of walking, renting private vehicles or being carried on traditional stretchers to access maternity health services in health facilities in the past. The thought of exposure to cold wind or scorching sun is a major deterrent for women to

[21] Traditional stretcher (traditional ambulance) is a carriage made with local materials, usually wood and strings, to carry patients to health facilities in rural settings of Ethiopia.
[22] Bajaj is a three-wheeler mini car used as taxi in Ethiopia.

access health facilities during childbirth. Women believed sunburn could make a laboring woman or new mother and her infant sick. Pregnant women and new mothers in Girar Jarso woreda have developed avoidance strategies by travelling early in the morning before sunrise or late in the evening after sunset. Other women opined that nothing could stop them from birthing in health institutions to protect their lives and that of their infants. Safety and comfort appeared to exert major control on women's decision-making process during childbirth. A woman's orientation towards safety or comfort invariably influenced where she birthed. This was reflected in the study by the number of women who voluntarily birthed in the health system versus those who only sought professional help in health institutions after protracted and complicated labor at home. Below are quotations elucidating some of the physical contextual challenges women in Adisge and Girar Geber face during childbirth.

There are some women living in other parts of the kebele who cannot easily birth in health facilities because of the remoteness of their residence (Sandra: HEW, Adisge).

Presumably it is the lowland's culture. When they [laboring women] travel in the bed (traditional ambulance) there is tangling. They may dislocate the fetus. The feeling is painful. That is why they choose to birth at home. I myself I did not want to go to the hospital to birth. Because during that time the road was not constructed (paved). It was full of rocks and chain of hills, it was dark too (Mercy: TBA, Adisge).

I was carried on human shoulder (traditional ambulance). I didn't come back home walking. My father gathered men to carry me home. The baby was embraced and

carried home by a woman. We come at night or very early in the morning before the sun rises (Patricia: Adisge).

Nowadays, there is an ambulance [conventional]. The ambulance would come to our home and take us to health center. But before the ambulance came we were going to hospital by the traditional stretcher. So by now there is a big difference (Brenda: Girar Geber).

Sometimes women walked to or from health facilities during childbirth. A woman expressed her anguish, pain, fear and uncertainties as follows:

I walked all the way to Ginno health center. I was taking rest when I felt tired. I was afraid that I could give birth in the middle of the road. I was in agony on the way to the health center (Alberta: Girar Geber).

A few women in Adisge and Girar Geber reported that they had to pay for taxi service or rent private transport to access health facilities for childbirth. The following is a quotation of a woman's testimony.

For the first child I used the traditional ambulance. For the rest three children I usually hired the vehicle for public transport (Victoria: Girar Geber).

Laboring women who could not afford to rent private vehicles were forced to travel in public transport to access maternity health services. A woman described her discomfort with the use of public transport during childbirth as follows:

Nothing makes it comfortable. It [was much] suffocated and it was not clean. I had to lean on my sisters and brother all the way to Fitche. I paid double price (Carla: Girar Geber).

Women in Adisge and Girar Geber expressed how logistical factors influenced their decisions to birth at home in related ways.

When I gave three births at home, I did not choose to give birth at home. Because it is very mountainous, it would be difficult to go to hospital (Jennifer: Adisge).

If the hospital was nearer than where it is now, we would like to give birth in hospital. We would take the encouraging needle [oxytocin] to make the child birth easy. But our village is very far from the hospital. There is a chain of hills to the hospital which impose difficulties to birthing women during the journey (Erica: Adisge).

Another woman buttressed the above sentiment as follows:

I felt sad to give birth at home. Do you know why? My choice was to give birth in hospital safely and clean. If it was in hospital I would not labour for so long. And the bleeding would not be too much. That was why I felt sad. I was wondering how the traditional birth attendants could help if the labour got severe during the child birth. I wished the health center to be very near to my house (Brenda: Girar Geber).

On the other hand, the introduction of conventional ambulance has increased the number of women birthing in health facilities in the study areas. Residents use traditional ambulance[23]

[23] Traditional ambulance is a locally made stretcher used to carry sick people and laboring women to health facilities in Ethiopia. Traditional ambulance is usually used in rural areas.

(locally made stretcher) to carry laboring women from remote locations to paved roads where conventional ambulance takes over. The synergy between kebele residents and ambulance operators in the health system has improved the birthing context and saved mothers and babies' lives. Figure 4-2 is a picture of ambulance navigating the rugged road from Adisge kebele to Fiche.

Figure 4-2: Ambulance navigating the road from Adisge to Fiche. [Photograph], by Tefera, A, 2014.

A grandmother expressed her joy about conventional ambulance service in her kebele as follows.

> *By now there is an ambulance. If someone is in labour in our village the HEW would call the ambulance they are easily unleashed in hospital peacefully on these days we are not*

afraid of our daughters dying of birthing complications. I am satisfied with the way health services are rendered for birthing women. So birthing women are going to hospital, having good childbirth experiences. I am very satisfied with all these things (Tanisha: grandmother, Adisge).

A traditional birth attendant added her perspective by saying:

Ever since the introduction of the vehicle transport [ambulance] birthing women these days give birth in hospital. At present, we have no concerns about the childbirth experiences these days. We would [carry] birthing women to and from hospital by vehicle (Tricia: TBA, Girar Geber).

4.2.1.6. Structural context

The nearest fully functional health facility to Girar Geber and Adisge is 12 and 20 kilometers away respectively. Both kebeles have health posts which are not equipped to handle complex obstetric emergencies. Birthing mothers in Girar Geber may access a nearby health center in Ginno; which is about 45 minutes' walk away. While Ginno health center has the human and material resources to assist normal delivery, the facility refers all complex obstetric emergencies to Fiche Zonal Hospital, which is about 15 kilometers away. A nurse and health extension workers team in Adisge assists normal delivery at the health post. However, the team refers complex obstetric cases to Fiche Zonal Hospital. The health professionals in Adisge and Girar Geber use the official referral system to transfer birthing mothers to Fiche Zonal Hospital. According to health officials, access to government ambulance is problematic for residents as there is one ambulance which serves the seventeen (17) kebeles of Girar Jarso woreda. Ambulance access is further complicated by remoteness of Adisge and Girar Geber, rugged

terrain and seasonal isolation (Adisge) due to road condition. Adisge has evolved from a community with no motorable road access in the past to one with seasonal accessibility by ambulance since January 2014. Although Adisge is nestled in the rugged Sefa river valley terrain, the government ambulance manages to navigate the snaking road to serve the community in the dry season. However, due to the topography and road condition, ambulance service to Adisge is cut off in the rainy season. The only options for laboring mothers in Adisge to reach health facilities in Fiche during rainy season are walking or by traditional ambulance. In contrast, Girar Geber is accessible to vehicular transport year round. However, due to the wide coverage of the official ambulance, sometimes residents are forced to rent and pay exorbitant prices for private transport to transfer birthing mothers to Fiche Zonal Hospital. In both Adisge and Girar Geber, laboring mothers are carried on traditional ambulance from their homes through gravel roads to paved roads where conventional ambulance takes over. The inconveniences and costs associated with buying food and alcoholic beverages for men who carry birthing mothers on traditional ambulance may deter women from birthing in health facilities. A few participants expressed that the attitudes of health professionals may influence women's decisions about choice of place of birth and birth attendant. According to participants, women who receive professional treatment within the health system are likely to return to health facilities to birth. However, women who felt neglected, scorned or abused by health professionals in the past may birth at home the next time. Women's accounts captured the dire structural conditions of the past and the evolving contemporary context which offers hope for their communities and birthing mothers in particular amid its shortcomings. The following are excerpts from women's transcripts.

During the first child birth the labour was so cruel. It was painful. There was nothing for birthing women. There was no vaccine. There was no health post or health center. There was no medical examination, it was not the same as today. I was pregnant at early age. I was only 16 when I gave birth to my first child. By the time the labour got severe my brothers decided to take me to hospital in Addis Ababa but my mother refused in fear of I could be endangered on the way to hospital. Fiche hospital was not built then. The only option was Addis Ababa. I gave birth after two days of labour my mother relied on mother Mary to help my child birth so my mother did not let us to go to hospital (Tanisha: grandmother, Adisge).

Health extension workers in the study areas expressed their frustration about their capacity to assist birthing women. They opined the one month midwifery training they obtained in school was inadequate to handle complex obstetric cases. This training gap thwarts their effort to assist birthing mothers at the health post.

We experience difficulty when a woman is bleeding during childbirth. We cannot help a bleeding woman to give birth at the health post. We do not have such knowledge and skill. We took training for midwifery only for one month. Besides it is most probable that you forget what you learned if you are not supporting birthing women regularly. Since we did not take intensive midwifery training we could not help birthing women at the health post. There are some serious birthing complications that we are not trained to handle (Sasha: HEW, Girar Geber).

Discrimination against rural women was cited as a major deterrent to health system birth. Participants intimated that health professionals in hospitals are insensitive to people from rural areas. There were reports of casual treatment to laboring mothers from rural areas in hospitals. A health extension worker succinctly described the varying attitudes of health professionals towards birthing mothers as follows.

> *The health professionals at the hospital do not feel good to see women dressed in rural clothes and may not give them quick attention when they arrive at the health facilities alone. People from town are treated differently (better) than people from rural areas. This often happens at the hospital (Sarah: HEW, Adisge).*

4.2.2. What women value about home birth

The values and preferences of birthing women and families significantly influence the choice of place of birth or birth attendant. Overwhelming majority of women who birthed at home indicated that home birth offered opportunity for control over their childbirth. Sense of belonging, privacy and confidentiality and opportunity to birth according to traditional norms and practices are important for women in Adisge and Girar Geber who birth at home. Women spoke eloquently about numerous childbirth rituals associated with home birth and their cultural significance. Cultural norms and traditions, quest for compassionate care, freedom of choice and support system were among the most important factors women cited as encouraging home birth in the study areas. Home birth is also perceived as cost and hassle free as it does not involve transportation to health institutions.

4.2.2.1. Sense of belonging

Some women prefer to birth in the comfort of their homes with the support of family, friends and neighbors. The support system provides a birthing woman with security and assurance that she is not alone. The home is a trusted environment which helps to alleviate anxiety and stress for the birthing woman. Women value the support they receive from families, friends and neighbors when they birth at home. In Adisge and Girar Geber childbirth is construed as community event. As a result, neighbors converge on a laboring woman's home invited or uninvited to offer moral or physical support. It is customary for community members to prepare coffee and food, sing and pray to God and Saint Mary or the god of the birthing woman's home for divine intervention when they gather at the home of the laboring woman. Men in the community stand guard to transport the laboring woman to a health facility or a location where a conventional ambulance may take over in case of birthing complications. This tradition provides social protection, comfort and hope for laboring women and their families. Therefore, when women birth at home in Adisge or Girar Geber they do not feel alone. There is a perception that birth attendants will share the birthing woman's anxiety with her and offer her physical, moral and spiritual support to make her childbirth experience pleasant. A grandmother clearly articulated this point by saying:

> *If a woman gave birth at home suddenly we would cook cultural foods like porridge and atmit[24]. We would be with her during the whole anxious periods of the child birth. Since we are women too we would feel what the woman would feel (Stacy: grandmother, Girar Geber).*

[24] Atmit is thin multi-cereal nourishing porridge indigenous to Ethiopia.

Another grandmother echoed the same sentiment with the following quotation.

> *They [villagers] would come to my home knowing that I am in labor. It doesn't matter whether they are men or women they would come as soon as they know I am in labor. They would come in numbers. If the labor stayed for days they wouldn't depart from me. They would wait until the childbirth is over. After we give birth they would go to their own home. We did this to each other turn by turn. That is we would support each other regardless of being our relatives or not (Amanda: grandmother, Girar Geber).*

A traditional birth attendant described the support for women birthing at home with the following words:

> *They would invite me after they watch fluid coming out. People from the neighbourhood would be summoned, those who could help the birthing [woman] would approach. The coffee ceremony[25] would take place. The coffee making would stay until the child birth is over. Then after with the help of mother Mary the [woman] would give birth to her baby (Nadia: TBA, Adisge).*

Women described their home birth experiences as follows:

> *By the time I feel pain when the labor is coming, I would send either a lad or my mother or my mother-in-law to call the person who can give the relief for me. When they call each other, they stuff themselves in a part of the house. They sit down, along there it is our country culture, they say may Mary approach you, may Mary approach you. From these women I choose one and say let you hold me (Erica: Adisge).*

[25] Coffee ceremony is a ritualized form of making and drinking coffee in Ethiopia.

One of them would make coffee, one of them would hold. One of them would tie the baby's cord. Some of them would take care of me. My mother was so anxious doing nothing. Some of them would cook the porridge. The traditional birth attendant would hold my buttock with neat patch of clothes. If the child birth ended peacefully, everybody would be pleased. Everybody departs with jubilation (Cynthia: Adisge).

The sense of community support during childbirth was further articulated by a mother as follows:

When I gave birth in Adisge my mother, mother-in-law and sisters-in-law, brothers-in-law, neighbors and traditional birth attendants supported me (Beatrice: Adisge).

Other women mentioned that neighbors attended their childbirth uninvited.

They would come by themselves. No one invites these people. They would wake up each other, make their way to my house as soon as they heard I was in labor (Maxine: Girar Geber).

I did not choose them. They called each other and came to attend my child birth. I did choose to give birth at home. They came on their own. They came to help during the child birth (Brenda: Girar Geber).

4.2.2.2. Cultural norms and traditions

Childbirth takes place in the context of cultural and traditional practices handed down by generations. Singing, praying and chanting are some of the traditional customs associated with childbirth in Adisge and Girar Geber. Also, there are rituals associated with childbirth support and burial of placenta after home birth. Women are afraid to birth in the health system

where these traditional practices are not observed. Most women birth at home with the assurance of birthing within cultural traditions handed down by generations. For example, to hasten childbirth, a hen was tied to the bed on which a woman labored, laboring women were asked to lean on Mary's cudgel (bludgeon)[26] and walk back and forth in the house or cattle were sent to their byre (den)[27]. The values women attach to these cultural practices motivate them to birth at home. Below are sample quotations reflecting these values.

> *After the child birth they would bury the placenta. My family members and neighbors would cook cultural foods like porridge and atmit. They would [chant] `elililil'. All people would gather to celebrate the child birth while eating and drinking (Stacy: grandmother, Girar Geber).*

> *Our parents would take us to their house for the first childbirth. There was such a culture in Adisge. My parents would prepare foods for the after-childbirth care. My father would come and ask my in-laws to let him take me home. There would also be a ceremony to take place in my in-laws' house. It was said to be a blessing ceremony. Finally my in-laws would let him take me back home (Verona: grandmother, Adisge).*

> *They [TBAs] would order or make coffee. They would also tell the woman's family to pray to the god of the family to help the childbirth (Sasha: HEW, Girar Geber).*

[26] Cudgel or bludgeon is a short thick stick used as a weapon.
[27] Byre is cow shed.

Overwhelming majority of women expressed their gratitude for cultural and traditional support they received when they birthed at home. There are several rituals associated with childbirth in Adisge and Girar Geber. Others relate to food service, protection of the new mother and the newborn, celebration of peaceful childbirth or mourning of unsuccessful childbirth. These cultural norms and traditions will be elucidated later. In the meantime, below are a few accounts of women's expression of appreciation for cultural and traditional practices associated with home birth in Adisge and Girar Geber.

> *If the labor is progressing slowly they [traditional birth attendants] would suggest the coffee ceremony to be held. They thought this could help the childbirth (Shamette: Girar Geber).*

> *By the time I was in labor, they (family) would invite her (traditional birth attendant) to attend the childbirth. As soon as she came to my house she would wash her hands and ask for butter. She put a piece of butter on her palm…then she thrust the hand with butter to everyone in the house [and] ask them to spit on it. After doing this she would rub the butter with spit on my stomach. She would say that the baby was coming soon (Erica: Adisge).*

> *They [birth attendants] cooked the genfo and atmit for me. They would embrace my baby after the childbirth. They would hold my body (Tiffany: Girar Geber).*

Another woman expressed her satisfaction with home birth as follows:

The attendants both the women and traditional birth attendant would cook the porridge, soup, atmit for us. There would also be honey. There would be something to eat what our appetite is in need of. They would cook the food with different kind for us. Butter would also be there to make the diet tasty. We would eat what we desire to eat (Portia: Girar Geber).

4.2.2.3. Privacy and confidentiality

Although childbirth is a community affair in Adisge and Girar Geber, birthing women expect some level of privacy and confidentiality whether they birthed at home or within the health system. Women believe their privacy and confidentiality are better protected with home birth than health facility birth. The layout of delivery rooms and birthing position on delivery beds in health facilities compromise privacy for many laboring women. A number of women who birthed at home indicated that they trust traditional birth attendants, families and neighbors to protect their privacy and confidentiality. This trust stems from family ties and kinship relationship with community members. Some women complained about exposing their nakedness to health professionals who are total strangers to them. This assertion is buttressed by the following statements made by participants.

There are those [women] who do not like their childbirth to be watched by strangers. They do not like even to be watched by health professionals during the childbirth so they have fear. They are afraid of going to the health center for delivery (Sasha: HEW, Girar Geber).

Because there wouldn't be a stranger. Everybody is intimate (within the family and neighbors). So they would spread around. They would cover the child birth with curtain. So no stranger would see me birthing (Erica: Adisge).

Parallel to privacy concerns is the issue of confidentiality so eloquently articulated by a health extension worker.

First of all they [laboring women] don't want to expose themselves to anyone. The TBA could be the woman's relative. If so, the TBA will not disclose any intimate things about the birthing mother to anyone. The woman believes that the TBA will maintain confidentiality (Sandra: HEW, Adisge).

Women trust their families, friends and neighbors to protect their privacy and maintain confidentiality when they birth at home. As a result, many women in the study who birthed at home indicated that their concerns about privacy and confidentiality influenced their choice of place of birth and birth attendant. Some women mentioned that they knew that health facility birth was cleaner and safer than home birth but they chose to birth at home to protect their privacy and confidentiality. Many participants in the study said childbirth is revealing and the stress of labor could make a woman say many things that she would not like to be revealed to the public. Therefore, women felt that it was in their interest to be surrounded by trusted people during childbirth. A participant endorsed the preceding statement as follows:

When you are living as person especially as a woman there are a number of things to be confided. So during the child birth these guys [mother, sister and neighbors] wouldn't

tell/reveal my secret to other people. They would conceal my secret and they wouldn't reveal it to anyone else (Cynthia: Adisge).

Another woman echoed a similar sentiment about confidentiality as follows:

Since my mother and sister were around I was afraid of nothing. That is because they would conceal my secret. I was not scared (Beatrice: Adisge).

4.2.2.4. Compassionate care

Undoubtedly, some women experience intense stress and anxiety during childbirth. The intrapartum and postpartum periods are marked with uncertainty as the woman contemplates childbirth outcome for herself and her baby. The fear of childbirth complications, death, deformed babies, exposure of private parts and insensitive care by birth attendants are part of the concerns birthing women may have. Culturally-sensitive and compassionate care may alleviate some of the anxieties women experience during the vulnerable moment of childbirth. Consequently, most women choose an environment where they feel confident that their physical, emotional, spiritual and cultural needs will be met to birth. Participants perceive that birthing women are more likely to experience compassionate care at home than health facilities. This is because when women birth at home in Adisge or Girar Geber they are surrounded by traditional birth attendants, families, friends and neighbors with whom they have kinship ties. Therefore, women make pragmatic choices between home birth with its known associated risks and health facility birth with superior medical care but no guarantees for compassionate care. A traditional birth attendant explained why women prefer to birth with her than health professionals as follows.

They [birthing women] said they would not know what the health extension worker do to her. They said the health professional would leave them alone while they were in labor (Nadia: TBA, Adisge).

The home provides opportunity for nurturing birthing experience as traditional birth attendants, families and friends provide tender care to birthing women. Two women articulated how much they valued their home birth experiences as follows:

When I gave birth at home I was supported by traditional birth attendants. They held me at the front and back. After I gave birth they tied the cord and put us (me and baby) in bed. There was no problem at all. There was happiness and joy among us (Suzette: Adisge).

I want them [family and neighbors] to share my feeling. They would fix everything for me. I could do nothing alone. They would pick up and lay the baby in bed (Mary: Adisge).

4.2.2.5. Freedom of choice and sense of control

Women value the opportunity to choose the inner circle of birth attendants during their childbirth at home. Although women accept the cultural notion of childbirth being a community affair, they want to have the opportunity to choose people with whom they are comfortable to be closest to them during childbirth. Women in Adisge and Girar Geber choose family members (especially mothers, sisters, mothers-in-law) or trusted friends and neighbors to cover their vaginal area during childbirth. Other community members attending the childbirth stay in the courtyard of the laboring woman's house from where they sing and pray for peaceful birth outcome. Women also value the opportunity they have to express their needs to birth

attendants when they birth at home. When women birth at home with close relatives and friends they are empowered to express how they want to be assisted.

> *I chose my mother and my sister. Not to be afraid of my thing [private parts]. They would hold me comfortably. They would obey me the way I order them to hold. That was why I chose them during the child birth (Laura: Adisge).*

A similar sentiment was expressed by another participant as follows:

> *Ay…they would come after they hear. After they come to my home, I would choose the ones I trust. To them I will say come in and hold me in your hands. Then I would give birth well. They are comfortable with me. They should hold delicately too (Catherine: Adisge).*

A mother elaborated that a woman exerts better control over her childbirth if she gives birth in her own home.

> *I gave birth at home. This is because I feel better at home than any other place. They don't even wash clothes as I like. For example, I don't order everybody as I used to do in my own home. I may not get the food that I have appetite for. But if it is in my home I would order food that should be cooked for me. If it is in my parents' home, I would not be able to order the way I like. This is because of the fear that it wouldn't be like my home. I am afraid of ordering people outside my house. I faced this problem once upon a time. So I want it [childbirth] to happen at home (Tamara: Girar Geber).*

There is a perception amongst women that a woman values the freedom to choose the inner circle of birth attendants when she births at home. A participant argued that when women

birth in the health system they sacrifice their right to choose birth attendants. The woman articulated her opinion as follows:

> *Even if it [childbirth] is at home I would choose women with knowledge to help me. The one who is capable of helping birthing women. But in the hospital how can we choose among the health professionals? (Christine: Girar Geber).*

4.2.2.6. Home birth is cost free

The cost associated with facility birth was cited as demotivating factor for health system birth and motivating force for home birth amongst women in Adisge and Girar Geber. Laboring mothers and their families were saddled with transportation cost in the past when there was no ambulance service to Adisge and Girar Geber. A woman in Adisge shared her hospital birth experience and compared it with what it could be if she birthed at home as follows:

> *But I went to the hospital on shoulders and again I dwelled in other peoples' home and [was] brought back home on human shoulder. What about the cost too…those who carry you would be paid or invited for drink...payment in the hospital. What if it is at home…coffee would be made. No cost, nobody would watch my naked body (Patricia: Adisge).*

A parallel sentiment was expressed by a woman in Girar Geber who paid for private transport to take her home after childbirth in a health facility in the past. The following quotation illustrates her experience and perception:

> *In the past there was no vehicle transport [conventional ambulance]. But I hired (my husband hired) a vehicle for 200 or 250 birr to take me back home. It was expensive. I was able to afford it because of my work as a trader. Some of them used the traditional*

ambulance not to pay even 150 birr. Some of them were suffering from birthing complications. They [husbands] had no money to take their wives to hospital. Anyways it was expensive. The reason why [I] covered the cost is I had already the money on hand because I have been working hard. For those who didn't it was impossible to pay 100-150 birr (Victoria: Girar Geber).

4.2.2.7. Home birth is hassle free

Many women asserted that home birth provides opportunity to escape the hassle of walking or being carried on traditional ambulance to health facilities when in labor. Women spoke about the discomfort of sunburn, chilly wind, tangling on stretchers and potential harm to themselves or their unborn babies on the journey to health facilities during labor. Other women mentioned that home birth allowed them to avoid bothering people to carry them on stretchers to health facilities. For these and other reasons mentioned earlier in this report, some women in Adisge and Girar Geber prefer home birth to institutional delivery. The excerpts below attest to what women value about home birth.

I wouldn't bother people to take me to hospital on the traditional stretcher (Laura, Adisge).

If the childbirth is at home there is no need of carrying the birthing mother on the stretcher (traditional ambulance). There is no dislocation of body parts of the mother, there is no dislocation of the fetus (Portia: Girar Geber).

Other women expressed similar feelings about home birth with the following statements

I dislike nothing about birthing at home. I wouldn't face the complications while going to the hospital. I wouldn't experience the up-side-down challenges. The sun wouldn't strike my body. Having spared myself from such problems I would be pleased I gave birth at home (Erica: Adisge).

We were believing that I would be good to give birth at home rather than going to hospital because we could be hit by the sunstroke [on] the journey to and from the hospital. We were thinking of this problem. It would discomfort us to come back home after we gave birth in hospital (Jennifer: Adisge).

4.2.3. Motivation for women to engage with health system during childbirth

The study participants identified a wide range of factors that they perceived motivate women in Adisge and Girar Geber to engage with health system during childbirth. Women's perspectives on the topic were similar in both kebeles. Some women spoke from their personal experiences or experiences of other women. Women who had birthed in the health system told stories of their childbirth experiences and their motivation to birth in health facilities. These women also expressed their perceptions of what they believe motivate other women in their kebeles to birth in the health system. The main motivating factors that emerged from participants' interviews were women's childbirth experiences in the past or present, influence of family and community members, health education and awareness, transportation and health system characteristics. These motivating factors operate individually or collectively to influence women's decisions to engage the health system during childbirth.

4.2.3.1. A woman's childbirth experiences: Past or present

Study participants perceived that a woman's personal childbirth experiences or experiences of other women's childbirth at home or in the health system may influence their choice of place of birth and/or birth attendant in the future. Women who had pleasant home birth may continue to birth in the comfort of their home. However, women who had complicated home birth or witnessed other women's ordeal during complicated home birth may birth their future children in health facilities. On the other hand, women's previous health system birth experiences may or may not motivate them to birth in health facilities in the future. This study revealed that women who had pleasant health system birth in the past or witnessed other women's professional treatment in health facilities return to birth in the health system. In contrast, women who had negative experiences or witnessed other women's bad experiences during childbirth in the health system in the past may not return to birth in the health system in the future. Women evaluate their childbirth experiences in the context of health professionals' attitudes, available resources, physical birthing environment and birthing positions, privacy and confidentiality, childbirth outcome, restrictions health professionals impose on them and their families, friends or neighbors among others. The attitudes of health professionals towards birthing women was important factor influencing women's decision to return to health institutions to birth. Birthing women expect health professionals to treat them and their families, friends and community members accompanying them to health institutions with respect and dignity. This study found that women who are appalled by their treatment may not birth in health institutions in the future and may discourage other women from birthing there. In the same vein, women observe the treatment other women receive during

childbirth in health institutions and formulate their own perceptions about birthing within the health system. These perceptions may influence women's choice of place of birth or birth attendants in the future. Below are examples of participants' perspectives on why women engage with health system during childbirth.

> *If the previous baby died during childbirth, they [women] will give birth in hospital because of the anxiety that the birthing complication could reoccur. It would give them a lesson that they should give birth in hospital. They would learn that giving birth in hospital is better. That is why they choose to give birth in hospital (Sasha: HEW, Girar Geber).*

> *Those who had a bad experience at home. When the labour stayed for so long (cruel), they would choose to give birth in hospital (Nadia: TBA, Adisge).*

A parallel sentiment was expressed by a health extension worker as follows:

> *Those women who have had different diseases before the childbirth would be afraid of giving birth at home. For example, birthing women who encountered problems related with blood would not give birth at home. For all reasons they would choose to give birth in hospital (Venice: HEW, Girar Geber).*

A grandmother succinctly explained multiple reasons for women to engage with health system during childbirth as follows:

> *They may have given birth in hospital previously. Or they might get the advice from the educated ones. Or they would learn from the health extension workers. Some of them would see their friends [birth] peacefully. They would witness both mother and the baby*

came home peacefully. During this time they would choose to give birth in hospital or health center (Abigail: grandmother, Girar Geber).

Other women in the study corroborated Abigail's perspectives as follows:

Those women who gave birth at home did not know the benefit of birthing in hospital. As of me I knew the benefit of it (birthing in hospital). Because I was harmed during my first child birth. The problem is that we only like to go to hospital when things are severe (serious). After we get hurt we go to hospital. That is the problem. We would not go until we face challenge (Beatrice: Adisge).

I have been to hospital with a friend of mine. So I saw the experience about hospital birth. They would support the child birth with the fluid. They would help me to give birth without difficulties. I will choose the hospital experience because I saw them helping my friend during her child birth (Maxine: Girar Geber).

They (health professionals) would give anesthesia for those women who are going to go through operation during childbirth. They do everything with heed (care). Since I was a worker in hospital I saw many useful things for birthing women in the hospital. So I decided to give birth in the hospital. I was treated well and nurtured the same way as I had seen health professionals help other birthing women (Roberta: Girar Geber).

This study found that some women are inspired to birth in the health system by stories they hear about other women's childbirth experiences in health facilities.

Although I did not go to hospital I heard about the hospital experiences. We would hear that women [birthed] in the hospital peacefully. Some of them went through operation during their child birth. Some of them would come back happily after the child birth (Janice: Adisge).

I want to give birth there [health facility]. I like to hear when women are talking about birthing experiences in health centers. There birthing women can get the needle [oxytocin]. Besides there is vaccination [injection]. They would become stronger after giving birth. They are not afraid of [sunburn] or any other illness. So I am curious to give birth there in health centers (Portia: Girar Geber).

Another woman expressed her motivation to birth in the hospital as follows:

I saw the treatment they have. During the first child birth I bled nothing. They stopped the bleeding immediately. Then they served me with meals. They gave me an injection for the nausea I felt (Hannah: Adisge).

A woman told a harrowing story of her friend's near death childbirth experience. The story has the potential to motivate women with deep-rooted cultural beliefs to rethink their decisions to birth at home. The following is her story:

There was my friend whose labor was very difficult. She refused to go to the hospital at the early hours of the labour. By the time she faced the agony they took her to Fiche hospital. She slightly escaped death by going there. Some of them who believe would say that it is all about St. Mary's will and permission to have a peaceful child birth regardless of its place (Rosina: Girar Geber).

A woman indicated her abhorrence for home birth motivated her to give birth to her children in the health system. Below is a quotation from her interview.

> *I would like to give birth in the health center or hospital. I gave birth to all my three children in the hospital. I have seen laboring at home. So what does it profit me to give birth at home? To give birth at home they will say to the pregnant woman drink some alcohol (Patricia: Adisge).*

Parallel to previous childbirth experiences, complications during current pregnancy or childbirth was cited by participants as a major motivating factor for women in Adisge and Girar Geber to engage with health system. Some participants alluded that women who experience complications during pregnancy or childbirth are likely to seek professional care in the health system. Bleeding, prolonged labor, retained placenta, tight womb, breech presentation and placenta prolapse were cited as the main complications that motivate women to access health facilities during childbirth. The quest to save the lives of mother and child during complicated birth overrides deep-seated cultural beliefs and motivates women and families to seek help in the health system. Women told harrowing stories of death and discomfort associated with childbirth complications in their communities in the past. They also told stories of resilience displayed by women in the face of dire childbirth complications. When birthing women experience complications, their families and the community rally support for the women to access the health system. The woman in labor may assert herself and demand speedy transfer to a health institution if she perceives delay or indecision amongst her family and neighbors. For some women engagement with health system is considered a second option to home birth due to their perceptions of health facility birth. Some women may lack the autonomy to make

birthing choices or may be grounded in local childbirth traditions. The following quotation illuminates this point.

> *There was my youngest sister. She was in labour on a day back some years ago. We invited a couple of traditional birth attendants to attend the child birth. They said we should stay at home for the labor was not on time or for she was going to give birth later. She experienced a lot of birthing complications during this time. They were only holding her at the back. I knew that she was suffering a lot. So I decided to take her to hospital. They said the health professionals could train on her. But I took her to hospital despite the traditional birth attendants' refusal to let me take her to the hospital. Then at the hospital the doctors said she got weak and hurt because of the delay at home. It was a hard child birth. Even it was difficult for the doctors. The baby did not come out easily. I was there with the health professionals while helping the child birth. She was weak and her body swelled up. After a prolonged stay in the delivery room she gave birth to a beautiful child. Since then I have been advising birthing women to go to hospital for the child birth (Abigail: grandmother, Girar Geber).*

Another quotation from Abigail reinforces how childbirth complications motivate women in Girar Geber to engage with health system during childbirth.

> *Of the women who gave birth at home I attended three of them. One of them gave birth at night. She gave birth to the fetus [baby] shortly. But the placenta did not come out immediately. We did the cultural thing… moving the woman up and down in order for the placenta to come out. She bled a lot. The blood was to the level of my shoes. She was*

in a severe condition. Finally, we took her to hospital. She saved her life in hospital (Abigail: grandmother, Girar Geber).

A health extension worker shared her perspective as follows:

Those [women] who have experiences in the hospital would give birth in the hospital. Those women who suffered from birthing complications and those who labored for longer period would give birth in the hospital. The suffering would linger in their mind so they would give birth in the hospital. Also they know the difference between birthing at home and in hospital. They know the benefits of birthing in health centers. So they would go to the health center during childbirth (Sasha: HEW, Girar Geber).

Other participants told stories that attest to the motivating power of childbirth complications for women in Adisge and Girar Geber to birth in health facilities.

When I gave birth to my oldest daughter the labor started in the evening. I passed the whole night in labor and a traditional birth attendant came to observe me. She ordered that I should be taken to the hospital since I was bleeding. We rushed to the hospital (Hannah: Adisge).

In my village (Gote) my sister-in-law was in labor. It was a year ago. The labor was so painful and acute. Then she told us that she wanted to urinate. Although the labor was painful it only lasted for two hours then it was over. But the placenta did not come out so she went to hospital for help. She gave birth to the placenta in hospital (Roberta: Girar Geber).

During my pregnancy I experienced a lot of complications. It pulled the heart down. I experienced it for months. As a result I planned to give birth in hospital (Rochelle: Girar Geber).

A participant explained in culture-bounded linguistic terms how prolonged labor motivates women to engage with health system. The following is her quotation:

If mother Mary would not come nearby when we are in labor we would be forced to go to the hospital (Mary: Adisge).

4.2.3.2. Influence of family and community members

During childbirth the community descends on the home of the laboring woman invited or uninvited. This tradition has been practised for generations in the study areas and is cultural expectation women have come to accept. Although a few women have their preferences regarding who they would like to attend their childbirth, they acquiesce to cultural norms and traditions. During childbirth the laboring woman, her family, health extension workers and the wider community make critical decisions to safeguard the life of the mother and her unborn child. While women are asserting themselves and increasing their decision-making autonomy during childbirth, their agency is subject to community scrutiny and validation. Participants asserted that if a laboring woman refuses to access professional care in the health system, the community exercises control over the woman and forcefully transport her to health facility for help against her will. This act is not perceived as indication of disrespect for the laboring woman but rather is a reflection of community's responsibility to protect the lives of its members. A grandmother expresses her position on laboring woman's rights as follows:

Yes. Her right is respected. But if she refused to go to hospital her right may not be protected. Because, we could force the woman to go to hospital regardless of her refusal (Anneka: grandmother, Adisge).

Similarly, if a laboring woman is not competent to make decisions due to complications such as unconsciousness, the community decides where she should birth her child, at home or health facility.

The birthing woman should decide. The law would enforce this. The health extension worker and health professional taught this to women in our village. But during her birthing the woman could be unconscious so the people around her would decide about her birthing whether it should be at home or in the hospital (Amanda: grandmother, Girar Geber).

Husbands are known to play an active role in decisions about where their wives birth in Ethiopia. This study supported that belief as participants asserted that husbands are in the center of decisions about the choice of place of birth or birth attendants for their wives. For example, a traditional birth attendant in Girar Geber described how husbands advocate for their laboring wives to be sent to health facilities for professional help.

They (men) say that we should send their birthing wives to hospital. They would speak to us that their wives should not be hurt from birthing complications at home. They would urge women to go to hospital during childbirth (Betina: TBA, Girar Geber).

Traditional birth attendants may play pivotal role in ensuring that birthing women access health system for professional care in the face of birthing complications. Although traditional birth attendants support normal deliveries at home and provide culturally-competent care for

birthing women, they (TBAs) encourage women with birthing complications to seek professional care. Traditional birth attendants believe they have a moral obligation to refer complex childbirth cases to health facilities to save the lives of mothers and babies. In addition, traditional birth attendants refer difficult childbirth to health institutions to protect themselves from blame and legal wrangling. The current public policy in Ethiopia requires traditional birth attendants to identify pregnant mothers in their kebeles and report their findings to health extension workers. Traditional birth attendants are not supposed to attend childbirth, unless they are trained traditional birth attendants residing in rural areas. Notwithstanding this government regulation, the study revealed that traditional birth attendants cautiously continue to attend emergency childbirth in rural areas with the caveat that they will refer complex cases to health institutions. As well-respected elders in society, traditional birth attendants counsel birthing women and their families about childbirth and encourage them to seek professional help when necessary. Below is a childbirth story of a traditional birth attendant.

> *I had a cousin whose wife was having her first baby in the night. That night they did not call me. She labored for a long time. When I got out they called me. When I went to her house she was tired. There were a lot of people inside and outside the house. I called her father and said to him bring the bed [traditional ambulance], she is dying. Why didn't you say anything yesterday? It is the tightness of the womb, the baby has to come out. When I said this, when they were about to bring the keg bed the old women refused. Then I said…you don't let her die. He (father) said to them (old women) it is none of your concern. He asked the men for support to take her to hospital. At 8:00 pm she was admitted at the hospital. The health professionals said if you didn't bring her early it*

could have been deadly. In less than an hour after her admission she gave birth. The young lady still praises me by saying "long live mama" (Mercy: TBA, Adisge).

4.2.3.3. Health education and Awareness programs

Community health education and awareness programs were cited by participants as major motivation for women to engage with health system during childbirth. There is a vibrant national community health education and awareness creation program around maternal health services in Ethiopia. In Adisge and Girar Geber, health extension workers conduct house-to-house visits to educate families on a wide range of health issues including family planning and maternity health services and uptake. The health extension workers collaborate with traditional birth attendants and women development armies to identify pregnant women and women with young babies to target them with health education and promotion activities. There is monthly or quarterly pregnant women conference in Adisge and Girar Geber where health extension workers and health professionals (including midwives) from nearby health centers educate pregnant women about maternity services available in the health system, risks associated with home birth and the benefits of health system birth. At this forum, health extension workers also tell traditional birth attendants not to attend home birth. Instead, traditional birth attendants are advised to refer laboring women to health extension workers at the health posts. Health professionals use this forum to answer questions pregnant women or their husbands may ask and clarify any concerns they may have about facility birth. The health professionals also give the telephone numbers of ambulance drivers to pregnant women and encourage them to call for transportation to health facilities if they need emergency help in the health system. In addition to educating and creating awareness amongst community members,

health extension workers coordinate the kebele level referral system. The referral linkages in Adisge and Girar Geber involve communications among health extension workers, kebele administration, women development armies, traditional birth attendants, ambulance drivers and sentinel health centers. The health education and health promotion efforts of health professionals is augmented by educational programs of Girls' Clubs in schools. Women in this study believe that the current health education program has increased the awareness about health system birth in their kebeles. As a result, more women are birthing in health institutions with positive outcomes. A health extension worker expressed her views about the health education and awareness creation program as follows:

> *When women are pregnant we follow them up. She follows the treatment (advice) we give her when she is pregnant. We have women in the kebele who identify pregnant women for us (HEWs). They also identify women with children less than a year. They give us the women's names and number. Then we visit her, we follow her up. When the women come to give birth at the health post we make them give birth with happiness. Without fear we advise her. We use gloves when we assist birthing mothers. We also follow up women after they give birth. We inject bleeding women with a needle, misoprostol (Sarah: HEW, Adisge).*

Another health extension worker lamented as follows:

> *There is a conference named pregnant women's conference. This conference is held quarterly or monthly. During such occasions we would tell the traditional birth attendants not to help birthing women at home in the presence of pregnant women. We*

would reach an agreement. Even in some events we would teach the pregnant women together with traditional birth attendants (Venice: HEW, Girar Geber).

A grandmother expressed her perspectives about increased use of health facilities by women for maternity and reproductive health services as follows:

We knew nothing when we used to give birth to our babies. We used to rely only on mother Mary. We didn't go to health center for medical examination. If we lost appetite we wouldn't go to hospital. The illness would leave us by itself. We were only relying on our natural immunity we didn't wash our clothes like pregnant women of these days we didn't have a balanced diet to eat. We were conceiving babies two or three months after the previous child birth. There was no use of family planning or contraceptives. Pregnant women of these days are monitoring their pregnancy in a good way. They would visit health center or hospital. They would receive the advice from the health extension worker. They are having a peaceful child birth these days. Their babies are healthy too since their child birth is peaceful (Tanisha: grandmother, Adisge).

A traditional birth attendant attributed the increasing popularity of facility birth amongst women in her kebele to involvement of health extension workers in community affairs.

They [health extension workers] are working for the community. They would look after pregnant women. By the time a woman is to give birth they would call the ambulance. It is for the sake of her [HEW's name] we are able to see these changes (Tricia: TBA, Girar Geber).

Other women praised the health extension workers for increasing their awareness about health system birth as follows:

In the previous time there was no advice from health professionals or any other professionals. We used to stay in labor for a week. There was no way to go to health centers. But such prolonged labor is obsolete after the health extension workers came to serve us. It has been 8 years since the health extension workers came to our village. They would give us education, vaccinate and conduct medical examination. Recently, they told us that there is an ambulance to take birthing women to hospital. They gave the phone number for the ambulance to call when we are in labor (Shamette: Girar Geber).

In the old times women used to give birth at home. This was because of their lack of awareness, plus there was no health center or hospital. There was no education concerning birthing in health centers or hospital. Today, women give birth in health centers or hospital. They know the benefit they can get when they give birth there. There is no one who doesn't know about birthing in hospital. They would talk about hospital birth at any gathering. They highlight the benefits birthing women attain if they give birth in health centers. But during the previous times we were shy to talk about birthing publicly or to a friend. That shyness has cost us a lot (Brenda: Girar Geber).

Participants enthusiastically expressed their gratitude for the current maternity education programs in their kebeles. The following are quotations from women's interviews:

There was a Girls' club in our school. We were having meetings usually. We have been discussing about [where] a woman should give birth to her babies. A woman should go to hospital as soon as she knows she is pregnant. She should visit the health professionals till the date of the childbirth. Besides the health extension workers were

teaching us where to give birth to our babies. The reason behind is that if a woman gives birth at home, the woman will be endangered to birthing complications. The health extension workers discussed a lot. They educated me to give birth in health center. That was why I went to hospital in the early hours of the labor pains (Gayle: Girar Geber).

I chose to birth in the hospital because during my pregnancy I learnt about birthing in hospital. The health professionals told me about it. That was why I went to Fiche. I needed no traditional birth attendant to attend my childbirth. My brother is a nurse. I even refused to be helped by him at home. Because they [health professionals] told me that my womb is small so I should give birth in hospital (Roberta: Girar Geber).

4.2.3.4. Transportation

Availability of transportation influences women's decisions to birth at home or in the health system. Participants purport that since the introduction of vehicular ambulance to Adisge and Girar Geber, the number of women birthing in the health system has increased. As mentioned earlier in this dissertation, women in Adisge and Girar Geber were concerned about their safety and the safety of their unborn children in the past. Laboring women had to walk two to four hours or were carried on traditional stretchers (traditional ambulance) or horseback to Fiche to access maternity services. Figure 4-3 is a picture of a person being carried on a traditional ambulance.

Figure 4-3: A traditional ambulance in Yilmena Densa in the Amhara Region in Ethiopia.
McKenna, N. D. (Photographer). (2013). [Online Image]. Wellcome Images. Retrieved September 18, 2015 from http://wellcomeimages.org/indexplus/page/Prices.html. Reprinted with permission as per creative commons by-nc-nd 4.0

Some women birthed on their way to Fiche. Other women suffered undue hardship from exposure to cold or hot wind (depending on the time of labor), discomfort of walking long distances on rugged roads while in labor, the restriction of being carried on a stretcher for hours or the dread of being carried on horseback while laboring. Undoubtedly, these conditions were major deterrent to institutional delivery in the past. Although Girar Geber had motorable road before Adisge, the kebele had no conventional ambulance service until recently. Some women reported they and their families had to pay for private transport to Fiche to access maternity health services as expressed by the following quotations.

> *In old days, there was no suitable situation for those who were referred to health center or hospital. Those who had money would hire vehicles as contract to take the women to health center or hospital. There were events when women gave birth on the way to the hospital. Nowadays, there is an ambulance. The ambulance would take birthing women to the nearest health center or hospital (Sasha: HEW, Girar Geber).*

> *Ever since the introduction of the vehicle transport birthing women these days give birth in hospital. At present, we have no concerns about the childbirth experiences these days. We would [send] birthing women to and fro hospital by vehicle (Tricia: TBA, Girar Geber).*

Adisge became accessible by motor vehicles in January 2014. However, due to the topography of the area, Adisge is accessible by vehicles only in the dry season. In the rainy season, the untarred road is washed away by torrential rain which leaves in its trail deep gullies unable for motor vehicles to cross. The only options for laboring women in Adisge to access fully functional health facilities during the rainy season are walking or being carried on local

stretcher 20 kilometers up a mountain to Fiche. Despite the seasonality of ambulance service to Adisge, women expressed joy and gratitude for the service. A grandmother expressed her happiness as follows:

> *I am feeling happiness for my daughters and granddaughters. The health professional would call the ambulance to take the birthing women to hospital. The public is feeling good about all these support of birthing women. Those who were unable to go to hospital are by now going without bothering their mind about cost they had been anxious about. Our mothers were passing such stressful birthing experiences (Tanisha: grandmother, Adisge).*

A health extension worker compared the past transportation situation to the present as follows:

> *Previously, they [laboring women] walked or went by traditional ambulance. In Adisge we have an organization called Development group. It comprises of 25 to 30 farmers. The leader of the development group coordinates traditional transportation services for women in labor. Members of the development group inform each other about women in labor. The members organize themselves in large numbers and transport the birthing mother to a health facility. The large numbers are needed due to the long distance to health center or hospital. It may take up to four hours. Nowadays, they [laboring women] go by ambulance. The ambulance service started this year (Sandra: HEW, Adisge).*

Another health extension worker buttressed the above statement as follows:

Before this time there was no vehicle. Women used traditional ambulance. They were transported on human shoulders or on the back of a horse. Now the ambulance started in 2014. Now birthing women are using the ambulance (Sarah: HEW, Adisge).

Participants believe the introduction of ambulance service has relieved families of financial burden associated with transporting laboring women in the past. The assurance of ambulance service has also allayed fears of the past and given women and their families hope during childbirth. However, the service is seasonal and unreliable at times in kebeles such as Adisge.

4.2.3.5. Health system characteristics

The overarching theme cited by participants to exert tremendous pull on women in Adisge and Girar Geber to engage with health system during childbirth was characteristics of the health system. The sub-themes identified under this overarching theme were professional care, cleanliness, comfortable birthing environment, ambulance service and integration of cultural childbirth practices into modern obstetric care. The health system characteristics operated in isolation or in tandem to provide positive or negative childbirth experiences for women. Invariably, a woman's interpretation of her health system birth experiences determines where she will birth next. Several women in this study perceived health facilities as safe, clean and comfortable environment for childbirth. Many participants asserted that health facilities provide adequate support to ensure the safety of new mothers and their babies. Many women trusted the knowledge and skills of health professionals and had confidence in the resources of the health system.

4.2.3.6. Professional care

Most participants revealed that professional obstetric services in the health system motivated women to birth in health facilities. Women's faith in the safety of health system was cited as a major influence on institutional birth amongst women in Adisge and Girar Geber. Women who perceive health professionals to be knowledgeable and capable of providing compassionate maternity care will birth in health facilities. On the other hand, women who had negative childbirth experiences with health professionals avoid institutional birth or will only seek professional help in case of childbirth complications. The following excerpts elucidate women's perceptions of professional care and its allure for institutional birth.

> *They took care of me professionally. They wouldn't squeeze my body as traditional birth attendant did. They gave some quinine. I gave birth peacefully. I felt happy for that. They had good heart for me. They sent [me] back home with good care (Seraphine: Adisge).*

Another woman expressed similar perception of health facility birth as follows:

> *In the health center I gave birth on time. I would not see myself bleeding, no bleeding in the health centers. But if it is at home the bleeding could last for more than two weeks. To stop the bleeding I should go to the health center where they would give me pills to stop the bleeding (Brenda: Girar Geber).*

A participant described the friendliness of health professionals who attended her childbirth and their professionalism in the following quotation:

> *After I gave birth to my children, they would talk and advise me like friends. They would sit beside me. They [said] there would be quinine for me. I experienced some kind of pain*

or like that. They also would advise to vaccinate the baby. They told me about different usage of contraceptive if wanted to use for next time (Victoria: Girar Geber).

Some women birthed in the health system because they perceived it to be safe for the mother and her child. The expression of faith in the safety of health system birth was demonstrated in the following quotations:

If I encountered a problem while giving birth the health professionals would support with that. If the womb is too tight, they know how to deal with that too. If they know they can support in the health center, they will help. If not they will refer birthing women to Fitche hospital immediately (Gayle: Girar Geber).

The only place where there is safe and clean child birth is the health center or hospital. Those who gave birth in hospital would recover immediately after the child birth. Why because the doctors would attentively monitor the mother's and the baby's health (Erica: Adisge).

A number of participants perceive the home as precarious environment for childbirth. The study revealed that when women are making childbirth decisions they reflect on lack of capacity to manage obstetric complications at home and the possibility for professional care in health facilities. Although few women buoyed by their faith and past experiences felt safe to birth at home, majority of participants believed the health system offered better protection during childbirth. The following excerpt illustrates a woman's perception of health facility birth.

Birthing at home is full of torture. If a woman births at the hospital they [health professionals] will stop the bleeding with a single needle (injection). If we give birth in the health center we wouldn't be tortured (stressed). When we birth at home we bleed a

lot, we experience enormous bleeding. They let or even forced [me] to drink some traditional drinks to remove the placenta. But all they had done to me was of no use (Linda: Adisge).

4.2.3.7. Cleanliness

Some women are motivated to birth in the health system because it offers clean birthing environment. Other women relish the idea of birthing in one room and moving to another (postpartum room) for rest and recuperation in the health facility. This contrasts with many women's reality at home where they rest in the same room they birth their children. The following are women's commentaries about their health facilities birth experiences.

It was clean. The room's hygiene was kept properly (Tanya: Adisge).

A participant expressed similar perception of hygiene in health facilities as follows:

I was helped by a traditional birth attendant in my village during my first childbirth. Nowadays I want to be in hospital when I am giving birth. I saw the difference in hospital. There I saw the cleanliness of the childbirth (Rosina: Girar Geber).

The above sentiment was corroborated by another woman as follows:

It is flawless to give birth in hospital. I was helped by professionals. So it was safe and clean. All medical equipment [were] clean and neat. If we gave birth at home, the materials/resources are not safe and clean (Carla: Girar Geber).

4.2.3.8. Comfortable environment

A few women in the study asserted that health facilities provide comfortable environment for birthing mothers. Some women found the delivery beds and physical setting of delivery rooms

comfortable. Women indicated such environment provides relaxing atmosphere for childbirth. The following quotations attest to women's perceptions of delivery rooms.

> *It was exciting room. There were different kinds of bouquet. They made us sleep next to these flowers. They put me in different beds. It is fascinating to give birth there. At home we would get on our knees and hold something with our hands. But in hospital we would relax ourselves on the bed and give birth peacefully while [lying] on the bed (Alberta: Girar Geber).*

Another participant echoed the above sentiment in her interview as follows:

> *I am comfortable with that [health system birth]. For example, if a woman is to labor at home, she would get on her knees which is uncomfortable for the birthing woman. But in the health centers, she would give birth while lying on comfortable bed. As of me I am comfortable with that (Gayle: Girar Geber).*

4.2.3.9. Ambulance service

Many participants indicated the introduction of ambulance service has motivated women to birth in health facilities. The ambulance service has relieved women of the burden of cost and carriage on traditional stretcher. A woman expressed her excitement for ambulance service in her kebele as follows:

> *Today's experience is very exciting, that ambulance takes women to health center or hospital for free. Even I should thank the government for that. I paid five hundred (500) birr to take me to hospital. It was in public transport. They carried me on the traditional ambulance until the main vehicle road. But now everything is for free. We are praising the government for providing us these free services (Christine: Girar Geber).*

4.2.3.10. Integration of cultural birthing practices

Throughout Girar Jarso woreda efforts are being made by health institutions to integrate cultural birthing practices in health institutions to attract laboring women. The introduction of traditional childbirth practices in a few health facilities in the study areas has motivated women to birth in the health system. Women value coffee ceremonies held in health facilities to celebrate the birth of their children. They also value the introduction of tea, porridge and other cultural meals associated with childbirth in the health system. The following excerpts from participants' transcripts attest to women's appreciation for emerging cultural birthing practices in health facilities.

> *The government has introduced the ambulance service for free. Besides after childbirth there is coffee ceremony for birthing women. There would also be porridge for birthing women. It was not available during the past (Christine: Girar Geber).*

The above sentiment was corroborated by another woman as follows:

> *After the childbirth, they put me in clean room, bed and clothes. I was very delighted for that. They also served us with meals. They gave us tea too (Victoria: Girar Geber).*

4.3. Cultural interpretations of childbirth practices

The interviews of participants revealed several cultural practices associated with childbirth in Adisge and Girar Geber kebeles. Some practices are common to both kebeles and have the same cultural significance. Other cultural practices were unique to each kebele. In order to gain insight into the cultural practices and their significance for childbirth, I

approached four elderly women in Adisge and three elderly women in Girar Geber for their interpretations. The cultural interpretations are presented below by kebele.

4.3.1. Adisge cultural interpretations

Cultural insiders provided interpretations of cultural practices associated with childbirth in Adisge. There are cultural practices associated with pain management, healing, placenta burial and baptism. In addition, there are cultural practices related to hygiene, rest, hastening childbirth and traditional birth attendants' roles in Adisge. It is important to view these cultural interpretations in the context of their significance and influence on women's childbirth decisions.

4.3.1.1. Hastening childbirth

To hasten childbirth in Adisge, a hen with the color of barley (brown) is tied under the bed on which a woman labors.

4.3.1.2. Coffee ceremony

At a coffee ceremony men and women gather to make and drink coffee. In Adisge, a coffee ceremony begins in the home of a pregnant woman as soon as she announces her labor. The ceremony continues until the child is born. It is believed that the coffee ceremony would ensure a peaceful childbirth. At the coffee ceremony men and women who have gathered at the laboring woman's house for moral and spiritual support would pray to the god of the laboring woman's house to intervene with the childbirth to ensure peaceful outcome. The natives of Adisge believe the coffee refreshes and eases anxiety and boredom for birth attendants. The laboring mother is given coffee and alcohol (tela or ail)[28] to drink to strengthen

[28] Tela or ail is a traditional beer from Ethiopia and Eritrea.

her for childbirth. While coffee is served, women prepare oil seed (nug) and bake traditional pancake for people attending the childbirth. This tradition is believed to ensure uncomplicated childbirth.

4.3.1.3. Placenta burial

The placenta of a baby boy is buried inside the house of a new mother whereas the placenta of a baby girl is buried outside. The cultural significance of this ritual is that a boy is expected to grow up and bring a wife home, while a girl will grow up and leave her home to join her husband. There is a belief amongst the natives of Adisge that placenta should be buried at the place of childbirth. However, if a woman gives birth on the road, the placenta will be taken to the mother's house for burial. Culturally, the placenta of a baby boy is buried beneath a traditional mill inside the mother's house.

4.3.1.4. House cleaning after childbirth

The new mother's house and surrounding compound are cleaned to make them attractive to visitors. Visitors will praise a new mother who keeps her house clean. She will be hailed as a good house wife. The mother is expected to participate in the house cleaning and dish washing to demonstrate that she is not lazy. The house and its compound are also cleaned for hygiene reasons. After the house is cleaned, a nice smelling wood is burned in the house to produce pleasant aroma.

4.3.1.5. Role of traditional birth attendants at childbirth

Traditional birth attendants (TBAs) in Adisge are culturally expected to provide free services to birthing women. TBAs are rewarded with porridge for their services. TBAs will be branded heartless and exposed to scandal or gossip if they asked for money for their services. A

cultural insider in Adisge lamented that her community will be upset and send birthing mothers to health facilities for help if traditional birth attendants insist on payment. Another cultural insider asserted that traditional birth attendants do not ask for money because they do not want to embarrass mothers and their families who may not be financially secured. Traditional birth attendants are expected to cook for women shortly after their childbirth. TBAs are not supposed to return to their homes while the new mother's stomach is empty. It is customary for TBAs in Adisge to give gifts to support the mothers whose childbirth they attend. TBAs chant elililil[29] on their way home after a peaceful birth attendance.

4.3.1.6. Rest and Baptism

A new mother is supposed to rest for 40 days if she gave birth to a boy and 80 days if it is a girl. It is perceived by society that a baby girl is weaker and needs longer nurturing than a baby boy. During respite, the new mother is not supposed to go outside alone or expose herself to sunlight. The new mother will be served with atmit and porridge, goat or chicken meat to heal the wounds of childbirth and rebuild her body. The mother may drink the blood of goat for fast recovery. The end of respite is marked by the baptism of the newborn. A baby boy is baptized on day 40 and a baby girl is baptized on day 80. Baptism is considered the right of passage to Orthodox Christianity amongst Orthodox Christians. If a woman gives birth to fraternal twins, the baby boy would be baptized on day 40 and the baby girl on day 80. The new mother is free to go out alone after her baby is baptized.

[29] Elililil is a traditional chant used by women to communicate peaceful childbirth in certain communities in Ethiopia.

4.3.2. Girar Geber cultural interpretations

Several cultural practices are associated with childbirth in Girar Geber. There are traditional practices believed to speed childbirth, strengthen mother and newborn after childbirth. In addition there are rituals surrounding placenta removal and burial, colostrum and celebration of childbirth.

4.3.2.1. Speeding childbirth

To expedite childbirth coffee ceremony is held continuously until the childbirth is over. It is believed that the aroma of smoked coffee hastens labor. Also to hasten childbirth cattle are sent to their byre (den) while a woman is in labor. The husband of the laboring woman loosens his belt as it is believed this action will loosen the birth canal of his wife. A traditional birth attendant puts butter in her palm and asks every person present in the house of the birthing mother to spit on it. After the spitting ritual the butter is rubbed all over the stomach of the laboring woman. It is believed that spitting helps to hasten childbirth. Women in the neighborhood gather in the house of a laboring mother and pray to Saint Mary, god of the laboring woman's household and god of the vicinity for their intervention. All the people attending the childbirth are required by tradition to stand while praying regardless of their age.

4.3.2.2. Strengthening mother and newborn

There are rituals that are observed in Girar Geber to strengthen women during and after childbirth. Also special rituals are practised to strengthen the newborn and protect it from evil forces. A laboring mother is given honey to eat to strengthen her back and spine for pushing out the baby. It is also believed that honey reduces labor pain. After childbirth the new mother is served oil seeds (e. g. linseed) and butter to replenish her energy. It is also believed that oil

seeds helps the new mother's stomach to become smooth and soft. The new mother remains on special traditional diet for at least one month after childbirth to nourish her body and regain energy. A goat or sheep is slaughtered after a woman gives birth. The woman is served with the meat to make her body strong and heal the wounds she sustained during childbirth. A new mother in Girar Geber is also served hot porridge and atmit (cultural porridge for new mothers) to help her to regain strength and heal her wounds. It is believed atmit helps a new mother to withstand pain from childbirth wounds. Only the new mother is supposed to drink atmit. Other adults are prohibited from partaking in atmit. However, children are permitted to drink atmit with a new mother. There is a cultural belief in Girar Geber that the body of a newborn could be strengthened by placing it on a sieve or wicker craft.

4.3.2.3. Placenta removal and burial

To remove retained placenta after childbirth, the husband of a new mother or men from the neighborhood could carry her (new mother) on their back and move the woman up and down. A sieve[30] could also be used to remove the placenta. In Girar Geber the placenta is believed to be a second baby with soul. Therefore, it should be handled with dignity and respect. The placenta is buried in the compound of the new mother with cereal grain (e. g. barley) and nail. The placenta could also be buried with any piece of iron or a blade with which the umbilical cord was cut. It is believed that the nail would prevent the baby from stomach perforation and maintain healthy stomach. The placenta of a girl is buried near the traditional mill in the house if there is one. This contrasts the practice in Adisge whereby the placenta of a

[30] Sieve is an instrument with a meshed or perforated bottom, used for separating coarse from fine parts of loose matter, for straining liquids et cetera.

baby girl is buried outside the house. Alternatively, the placenta of a girl will be buried on the left side in the family compound and the placenta of a boy will be buried on the right side of the compound. It is culturally prohibited to bury the placenta in another person's house.

4.3.2.4. Celebration of childbirth

A peaceful childbirth is celebrated with singing, chanting and porridge drinking in Girar Geber. Men in the neighborhood of the new mother would sing traditional song "kawo"[31] to celebrate a pleasant childbirth. Kawo is also used to announce peaceful childbirth to community members when the childbirth occurs in a health facility. Men would sing kawo to announce their happiness as they return from a health facility following a successful childbirth. The men would drink locally made alcohol known as "areke"[32] as they sing kawo. On the other hand, community women would gather and chant "elililil" to celebrate the birth of a child. On the 3rd or 5th day after the birth of girl or boy respectively, the community will cook porridge in honor of Saint Mary for protecting the mother and child during childbirth. The porridge will be prepared with linseed, butter and pepper. The oldest man or woman at the ceremony will bless the porridge, drop a loaf of bread in the porridge, remove it and put it on the ground. After this ritual it is believed the porridge will not be intended to celebrate labor pain but to honor Saint Mary. During the ceremony women will wash the baby's clothes, burn old clothes stained in blood and dress the baby with a new one. The women will be served with porridge after the clothes washing ceremony.

[31] Kawo is a traditional chant used by men to announce or celebrate peaceful childbirth in certain communities in Ethiopia.
[32] Areke is a traditional beer produced in Ethiopia.

4.3.2.5. Baptism after childbirth

A new mother takes postpartum respite for 40 days or 80 days for a baby boy or girl respectively. The mother is prohibited from going outside for fear of sunburn. After 40 days of giving birth to a boy or 80 days for a girl, the mother and her baby are baptized by a priest. It is believed baptism protects the mother from Satan and also makes her strong. The people who attended the woman's childbirth are deemed impure and are also baptized along with the mother and her child. The birth attendants are not allowed to enter the church until they are baptized. The baptism takes place at the house of the new mother.

4.3.2.6. Colostrum handling

The cultural insiders said in Girar Geber colostrum is not fed to the newborn. Instead, it is poured on the ground as it is believed to cramp or contract the baby's stomach.

4.4. Reflections

A number of notable findings were uncovered in this study. Given that Ethiopia is a patriarchal society, it was astounding to learn from participants that some women in their societies are able to exercise self-determination during childbirth. The level of submission men display to their wives, traditional birth attendants, grandmothers and other community members during childbirth is uncommon in their everyday lived experiences. It was breathtaking for me to learn about women's level of awareness about family planning, health system birth and knowledge about misoprostol and oxytocin. It was a pleasant revelation for me to read from participants' transcripts that women almost unanimously support health system birth. While majority of women expressed privacy concerns about the delivery bed, a few women indicated it was comfortable to birth on. Another unexpected finding was that

some women who birthed at home perceived kneeling birthing position uncomfortable. It was encouraging to learn from participants that traditional birth attendants and grandmothers in Adisge and Girar Geber are actively advocating for younger women in their kebeles to birth in the health system. Some traditional birth attendants expressed their joy over abolition of female genital mutilation[33] in their society. Some TBAs in this study were worried that their profession is under threat as older generation of TBAs are dying and younger generation of women are not interested in learning the trade of traditional birth attendance. Other TBAs believe their services are no longer valued and are craving for recognition. It was fascinating to learn about traditional birth attendants' effort to maintain hygiene during childbirth attendance. TBAs spoke vehemently about hand-washing and using clean clothes, knives and thread to support birthing women. Given the number of participants who had complicated homebirth or witnessed other women's complicated home birth, it was surprising to know that childbirth-related deaths were few in the study areas. Further, it was astonishing to know that almost all the women who birthed at home reported precipitous birth. Although Adisge and Girar Geber are two separate linguistic societies, there were striking similarities between childbirth traditional practices in the two kebeles. The level of community involvement in childbirth decision-making and attendance symbolizes strong kinship ties in the study kebeles. The notion of childbirth as open invitation to community members was new to me. The elevation of food, coffee and drinks at childbirth in the study areas was remarkable. A few participants opined that laboring women are given traditional alcohol to drink to boost their energy for childbirth. It was confusing to know that despite the known risks associated with

[33] Female genital mutilation is the ritual removal of some or all of the external female genitalia.

home birth, a few women in the study perceived home birth to be safe. One of the most culturally and contextually significant findings of this study was a story told of a traditional birth attendant in one of the study kebeles who attempted Caesarean section during birth attendance. A story was told that a TBA convinced a woman who experienced complications during childbirth and her family to allow her to cut the woman's belly to take out the baby. When permission was granted the TBA cut the woman open, removed the baby but did not have the resources to stitch the woman back. According to a participant the woman bled profusely while she was being carried to Fiche hospital. Upon arrival at the hospital, it was said the doctors told a crowd of on-lookers that whoever started the surgery must finish it. The TBA was arrested by the police. The preceding story attests to the extent of TBAs vilification in Ethiopia. The doctors at the hospital did not see the good intentions of the TBA to save the lives of the mother and child. Instead, they saw recklessness in her action.

4.5. Conclusion

In this chapter, I have described the context in which women live and birth in Adisge and Girar Geber kebeles. The chapter shed light on the multiple ways in which women's living context influence their childbirth decisions and choices. In this chapter, I have elucidated the evolving childbirth context, women's increasing awareness, empowerment and tension between women's right and communal authority. This chapter presented women's account of factors which motivate them to birth at home or in the health system. Further, this chapter is replete with women's account of the challenges they face during childbirth. The extenuating factors that influence women's place of birth and choice of birth attendants are documented in this chapter. In addition, I have presented in this chapter the role of the community in

childbirth in Adisge and Girar Geber. I have also included in this chapter the interpretations of cultural insiders on traditional childbirth practices and their significance for birthing women and their communities. I concluded this chapter with my reflections on the data collected in this study.

Chapter 5: Discussion

5.1 Brief introduction

In this chapter I provide a brief history of childbirth in Ethiopia which lays the foundation for discussion and interpretations of the study findings. I also present the rationale for framing this study's findings in social constructionist epistemological lens for analysis and interpretation. In addition, I reiterate in this chapter the study purpose and data collection approaches used. Further, I present barriers and facilitators of institutional birth, the importance of transportation during childbirth, and women's perceptions of home and institutional birth in Girar Jarso woreda. In this chapter, I elucidate the tensions between HEWs and TBAs in the delivery of community maternity health services, the role of religion, culture and authority in childbirth as well as the use of birth plans amongst women in Girar Jarso woreda. Also in this chapter I discuss women's preference for HEWs and power shifts associated with childbirth in Girar Jarso woreda. Finally, I conclude this chapter with three summary assertions about childbirth in Girar Jarso woreda.

5.2. Historical, theoretical and epistemological lenses

Framing the findings of this study in social constructionist epistemological lens was helpful to identify the socio-cultural influences on women's childbirth decisions in Girar Jarso woreda. The social constructionist lens provided opportunity for me to analyze and interpret the study data with open-mind, without judgement or manipulation, and willingness to accept women's stories as authoritative. This epistemological stance allowed me to understand women's childbirth decisions within the context of their culture and traditions, personal childbirth experiences, and childbirth experiences of other women. Framing the discussion and

interpretations of this study's findings in intersectionality theory and social constructionist epistemology facilitated explication of the multiple axes of inequality that coalesce through the forces of gender, economics, socio-culture, structural and educational factors to impact women's birthing experiences and perceptions of childbirth and women's social construction of their lived experiences with childbirth in Girar Jarso woreda. Using intersectionality frame, the discussion of this study's findings focused on explicating how social locations, gender, patriarchy and other contextual factors interact to shape and influence women's birthing experiences in Girar Jarso woreda (Hankivsky, 2012). The discussion highlighted social construction of gender roles in Girar Jarso woreda and how this mediated birthing decisions and choices in the study areas.

For centuries, women in Ethiopia have traditionally birthed at home with or without assistance. Grandmothers, traditional birth attendants and ordinary community members have played pivotal roles in supporting home birth in rural settings of Ethiopia. Although home birth is widely condemned as risky by health professionals, there is evidence to suggest that home birth can be a safe and rewarding experience for women and their families (Bedford, Gandhi, Admassu & Girma, 2013). As a bio-social phenomenon, childbirth and decisions associated with it can be understood in the context of biological, cultural, religious, and social factors that intersect to influence birthing outcomes. In addition, economic, geographical and structural factors are known to impact childbirth decisions and outcomes (Abdella, 2010; Bailey, Keyes, Parker, Abdullah et al, 2011; Worku, Yalew & Afework, 2013). This dissertation explored women's experiences and perceptions of childbirth in Girar Jarso woreda of Ethiopia. As mentioned elsewhere, this dissertation employed qualitative research methodology to collect

data from women regarding their childbirth experiences and perceptions through focus group discussions, in-depth interviews, observations and cultural interpretations. In the following pages, I present interpretations of the study findings to illuminate the contextual influences on childbirth in Girar Jarso woreda of Ethiopia.

In the past three decades, the Ethiopian government has attempted to revolutionize childbirth through a number of initiatives, policies and programs aimed at discouraging home birth while simultaneously encouraging institutional delivery. The introduction of health extension workers, women development armies and abolition of fees for maternity health services in public health centers are a few examples of such initiatives (Koblinsky, 2014; Pearson, Gandhi, Admasu & Keyes, 2011). While these initiatives are promising, they operate against established cultural and traditional norms. Convincing women to birth in health institutions against traditional birth practices has proven difficult. This demonstrates that changing the course of tradition requires a slow and painstaking effort. Further, some community elders in Ethiopia use inter-generational power to stop women from birthing in the health system. Hence, women's birthing intentions are not borne out. As a result, Ethiopian government's "childbirth revolution"[34] is gaining traction at a slow pace. Despite resistance to institutional birth by some women, most women in the study praised the government for improvements in the context in which they live and birth. The Health Sector Development Program introduced by the Ethiopian government has created opportunities for rural women in Girar Jarso woreda to birth in health facilities. Elderly women are excited about the emerging

[34] Childbirth revolution refers to Ethiopian government's aggressive effort to reduce home birth and maternal and child mortalities through policies, programs and initiatives that promote institutional birth.

context and are grateful for their daughters' and grand-daughters' access to free maternity health services in the health system. In the past, women in Girar Jarso woreda were forced to birth at home with no option for institutional delivery. However, women in Girar Jarso woreda now have the option to choose institutional birth. Health education programs led by health extension workers in the woreda have increased women's awareness and encouraged institutional birth. The program's success can be attributed to the collaboration between health extension workers, traditional birth attendants and women development armies at the kebele level, introduction of ambulance service and abolition of fees for maternity health services in public health centers. Some women have begun to question the safety of home birth in light of their increased awareness, availability of health facilities, ambulance services and abolition of fees for maternity health services in public health centers.

Despite moderate increase in institutional birth in Girar Jarso woreda, uncertainty about the quality of maternity services in the health system discourages some women from birthing in health institutions. This finding is consistent with a previous study conducted in Northwest Ethiopia which suggested providing incomplete (poor quality) maternal service had a damaging effect on health-seeking behavior of mothers (Worku, Yalew & Afework, 2013). Positive or negative birth experiences influence women's choice of place of delivery in Girar Jarso woreda. Participants opined that women generally returned to birth in the health system once they had positive birthing experiences with it. On the other hand, women who had negative childbirth experiences in the health system were unwilling to return to birth there. Similarly, women's choice of home birth in Girar Jarso woreda is influenced by their past home birth experiences or experiences of other women. These findings are consistent with other studies which revealed

that women's previous birth experiences influence where they birth next (Okafor, Ugwu & Obi, 2015; Kyomuhendo, 2003). The recent increase in institutional birth in Girar Jarso woreda is tempered by myriad socio-cultural, religious, economic, personal and structural barriers. The literature suggests uptake of maternal health services in low-income countries can be influenced by sociodemographic characteristics, cultural context and accessibility of such services (Gebrehiwot & Tewolde, 2014; Worku, Yalew & Afework, 2013).

Childbirth in Girar Jarso woreda is a community affair. As a result, childbirth decisions are made in a complex web of hierarchical structure, with the wishes of women and their husbands often over-turned by community members. The convergence of cultural norms and women's disempowerment resulted in lengthy delays in seeking professional care for laboring women in Girar Jarso woreda. Women's domestic and farming responsibilities influenced their childbirth decisions. Sometimes women had to weigh their decisions to birth in health facilities against their traditional domestic and farming roles. A few women in the study refused to birth in health institutions because of their concerns about their families, animals and crops. The study revealed that women are currently asserting themselves and pushing against traditional childbirth decision-making norms in their society. This cultural rebellion stems from women's increased awareness about the risks of home birth vis a vis institutional birth. Women are aware that a community-style decision-making process may result in delays in accessing professional maternity health care and cause them pain, discomfort, or loss of life during childbirth. Despite the general subjugation of women in the study areas, a few women in the study claimed they exercised autonomy in decisions about their childbirth. This finding contradicts the notion of powerless, docile Ethiopian women without agency and reinforces the

belief that women in patriarchal societies can occasionally assert themselves in ways that are beneficial to their welfare (Bedford, Gandhi, Admassu & Girma, 2013; Woldemicael & Tenkorang, 2010). This finding contradicts other studies which reported women's lack of self-determination in matters related to reproductive health (Roro, Hassen, Lemma, Gebreyesus et al, 2014). Thus overall and from social constructionist viewpoint, I argue that childbirth empowers women in Girar Jarso woreda to rethink what is good for them and consequently make decisions to fulfill their needs. Parallel to the complex hierarchical decision-making process is the impact of privacy and confidentiality on childbirth decisions in Girar Jarso woreda. Despite the nation-wide push for institutional birth, women in Girar Jarso woreda who are grounded in cultural traditions prefer to birth in the privacy of their homes. These women are uncomfortable to expose their intimate body parts to male health professionals whom they consider strangers. However, other women expressed they had no problem accepting care from male health professionals during childbirth. These orientations could possibly be explained in terms of social adoption potential of women. Social influence and diffusion concept suggests adoption rate increases as the number of a person's social network adopting a technology, asset or practice increases (Young, 2009; Bakshy, Karrer & Adamic, 2009). This is achieved through information sharing and vicarious learning. Women in Girar Jarso woreda share their institutional birth experiences with other women. This sharing has the potential to change women's perceptions of institutional birth and allay their fears about exposing themselves to health professionals during childbirth.

Women who birth at home trust the traditional birth attendants, families and neighbors to provide culturally-sensitive care during childbirth. The majority of women in the study who

had experienced home birth indicated they trusted their birth attendants to maintain confidentiality. For these women, institutional birth is second option. These findings suggest that until women feel confident in the privacy of health institutions and trustworthiness of health professionals, there will be no major increase in the number of institutional births in Girar Jarso woreda.

5.3. Institutional barriers

The major barriers to institutional birth inherent within the health system in Girar Jarso woreda include attitudes of health professionals, hasty medical interventions, loss of control, lack of support for allowing family in, and lack of ability to follow cultural practices. Other institutional barriers are associated financial cost, lack of knowledge of new policy of free maternal health services, unclear policy communication, and no choice of birthing position. In Girar Jarso woreda some women birth at home to avoid perceived or real unprofessional, insensitive and rude attitudes of health professionals in the health system. Birth stories spread quickly through community communication channels in Ethiopia. Negative institutional birth stories obtained through hearsay or personal experiences cause ambivalence about health system birth amongst women in Girar Jarso woreda. The stories of neglect, abuse or sheer insensitivities of health professionals discouraged some women in the study from birthing in the health system. The attitudes of health professionals in Girar Jarso woreda complicate birthing choices as women balance the safety of institutional birth against the indignity they might face when they deliver in the health system. Hasty medical interventions including cutting (episiotomies) discourage women from birthing in health facilities in Girar Jarso woreda. Women's voices are silenced when they birth in health facilities. Most women in the study

sensed that they lost control over their own bodies when health professionals invaded their bodies with interventions without their consent. Women labored in pain when they were told by health professionals not to scream, cry or bring families and friends to delivery rooms for support. Women's concerns about episiotomy in Girar Jarso woreda resonate with a study in Bangladesh which revealed that older women held many misconceptions about episiotomies and were frequently opposed, maintaining that they had delivered babies without this invasive practice and that tears were a natural outcome of delivery that healed on their own (Blum, Sharmin & Ronsmans, 2006). Women in Girar Jarso woreda feel lonely in delivery rooms (with health professionals present) as relatives and friends are not allowed inside. A similar finding was reported by a study in South central Ethiopia in which focus group discussants agreed that women prefer to birth at home because laboring mothers are not allowed to bring family members as support system to health centers and hospitals (Roro, Hassen, Lemma, Gebreyesus et al, 2014). Although placenta burial rituals are very important to women in Girar Jarso woreda, health professionals did not package placenta for women and their families to take home for traditional burial. Women grounded in tradition refused to birth in health institutions for this and other culturally-relevant reasons. There appears to be disconnect between government efforts to improve institutional birth and cultural expectations of women in Girar Jarso woreda during childbirth.

Financial cost associated with institutional birth is a major barrier for women in Girar Jarso woreda. While there may be no official cost associated with health system birth, laboring women and their families may have to expend money on food and alcohol to reward men who carry women in labor in traditional stretchers to health facilities or conventional ambulance for

onward transportation. This finding is corroborated by studies elsewhere in Africa that women's limited decision-making power as well as constrained economic resources, can inhibit their ability to seek health services and/or contribute to delays in accessing and receiving medical care even in places where services are readily available (Rutaremwa, Wandera, Jhamba, Akiror et al, 2015; Sipsma, Callands, Bradley, Harris et al, 2013). It is therefore imperative to evaluate women's childbirth decisions not only in socio-cultural and structural contexts but economic context. Ignorance played a pivotal role in where women birthed in Girar Jarso woreda. The study revealed communication gap about free maternity health services in public health centers in Ethiopia. Some women birthed at home because they believed they had to pay for institutional birth. The Ethiopian government failed to communicate effectively a dual-policy that proclaimed free maternity health care in public health centers but not in hospitals (Pearson, Gandhi, Admasu & Keyes, 2011). The dual-policy has created confusion amongst rural women and can be partly blamed for women's reluctance to birth in health institutions in Girar Jarso woreda. Some women refused to birth in health centers for the fear of forward referral to hospitals where they had to pay for maternity health services. Unclear policy communication by the Ethiopian government could be blamed for this confusion. Chiriboga (2009) asserts that enacting a law is not sufficient; the actual implementation plan is critical to ensure the targeted population takes advantage of the benefits offered.

The perceptions of women in Girar Jarso woreda about delivery beds influence their place of birth. Women who found lithotomy positioning on delivery beds revealing were unwilling to birth in health institutions. These women would normally birth at home. This

finding suggests that accommodating women's preferred birthing positions by health professionals would invariably increase the rate of institutional birth in Girar Jarso woreda. Despite the many disquieting criticisms and perceptions of institutional birth, almost all women interviewed agreed that women should birth in the health system. However, the participants cautioned that pregnant women should exercise agency in decisions about where they birth. Woldemicael and Tenkorang (2010) asserted that understanding the relationship between autonomy and maternal health-seeking behavior is particularly important for Ethiopia, where patriarchy and social norms limit women's freedom to make important decisions. Notwithstanding the disparate commentary on institutional birth, some women expressed favorable experiences and perceptions of health system birth.

5.4. Facilitators of institutional birth

The main facilitators of institutional birth in Girar Jarso woreda include health professionals' knowledge and attitudes, skills, and ability to manage pain. Other facilitators of institutional birth are cleanliness of birthing rooms and integration of traditional birthing practices. Women value knowledgeable, compassionate and respectful health professionals during childbirth. Most women in this study would birth in health facilities where birth attendants provide respectful, compassionate and culturally-competent support. In addition, health professionals' skills featured prominently in women's choice of institutional birth. Almost all women in this study cited risk management as a reason for choosing institutional birth. Women feel comfortable birthing with health professionals who have the knowledge and ability to identify and manage childbirth complications. Medical management of pain by health professionals in health institutions was a major reason for women to birth in health facilities in

the study areas. This finding is supported by a study at Gandhi Memorial Hospital in Ethiopia which found that poor pain control was the leading cause of dissatisfaction amongst women during labor and delivery (Melese, Gebrehiwot, Bisetegne & Habte, 2014). The cleanliness of birthing rooms and availability of postpartum rooms offered appeal for women to birth in the health system. Women who birthed in the health system revealed it was refreshing for them to cuddle their newborns in clean postpartum rooms away from the splash of blood in delivery rooms. Health facilities that integrate traditional birthing practices are preferred locations for childbirth in Girar Jarso woreda. Most women in this study desire to birth with the assurance of skilled birth attendants and also an opportunity to enjoy aspects of traditional birthing practices. The preceding discussion affirms that women's childbirth decisions are made with consideration to safety, cultural and behavioral concerns.

5.5. The importance of Transportation

The introduction of ambulance service to Girar Jarso woreda has ignited passion in women to birth in health institutions. Unfortunately, the ambulance service is unreliable as the woreda with 17 kebeles has only one service ambulance. According to woreda and zonal health directors, there is high demand on the single ambulance serving Girar Jarso woreda. Several women in the study wound up birthing at home when they could not readily access ambulance service to health facilities during labor. These women asserted that had they accessed ambulance service or had their labor prolonged, they would have birthed in the health system as they had the desire to do so. Women who could not walk or be carried on traditional stretcher, horse or donkey back to health facilities during labor birthed at home, sometimes against their will. Women perceived stretcher transportation to be unsafe to the laboring

mother and unborn child. This perception explains why some women in the study prefer to birth at home or be transported in conventional ambulance to health institutions during labor. Participants bemoaned one-way service offered by the ambulance in Girar Jarso woreda. Some women refused to birth in health institutions because they were aware that the ambulance will not give them return service after childbirth. Therefore, it is reasonable to say that unreliable ambulance service contributes to the high rate of home birth in Girar Jarso woreda.

A study by King, Jackson, Dietsch and Hailemariam (2015) revealed that free ambulance and maternity health services in Afar region, Ethiopia improved women's capacity to access health services. In addition to poor ambulance services, geographical isolation, bad road conditions and absence/unreliable public transportation system creates undue hardship for women during childbirth in Girar Jarso woreda. Sometimes laboring women had to travel in crammed public vehicles to access maternity health services in Fiche. Alternatively, women walk, ride on horse or donkey back or are carried on traditional stretcher to access health facilities during childbirth. These findings are corroborated by other studies in Ethiopia which revealed that long distances and inaccessible roads hinder women's access to institutional birth (King et al, 2015; Wilunda, Putoto, Manenti, Castiglioni et al, 2013). Transcripts from this study are replete with stories of women who birthed on the roadside while travelling to health institutions to birth. In attempt to avoid the vagaries of weather and discomfort of travelling to health institutions to birth, some women in Girar Jarso woreda decide to birth at home.

5.6. Women's perceptions of home and institutional birth

Since every childbirth is a unique experience, women's perceptions of home and institutional birth varied. Women's perceptions of home or institutional birth were influenced

by the support and care they received during childbirth, their educational status, religious beliefs and age. Some women were ambivalent about home birth because it offered comfort and cultural birthing options but failed to provide safety for the mother and child. Other women vehemently rejected home birth and branded it primitive and backward. Some women asserted that home birth is part of their culture which they cannot ignore. Similarly, women's conflicting perceptions of institutional birth stems from differences in what women value during childbirth. Women who value safety over cultural norms had favorable perceptions of institutional birth. On the other hand women grounded in cultural and religious beliefs perceived institutional birth as second option. This disposition had the tendency to create anticlimactic experience for women during childbirth. Therefore, women's perceptions of home or institutional birth can be seen as a constellation of experiences, beliefs and expectations.

Many elderly women in Girar Jarso woreda have favorable perceptions of institutional birth. They believe the younger generation of women in their woreda are blessed with an opportunity to birth in safe and clean health facilities with assistance of skilled health professionals. The general mood of elderly women in the study was one of excitement about improved childbirth context and the pride in their ability to encourage their daughters and grand-daughters to birth in the health system. Grandmothers and traditional birth attendants spoke with pride about their involvement in referring laboring women to health institutions to birth. This is an encouraging finding because grandmothers and traditional birth attendants in Girar Jarso woreda play central roles in birthing decisions in their communities. Grandmothers and TBAs in Girar Jarso woreda perceive institutional birth to be safe. As a result, they only attend precipitous childbirth and refer all other births to health facilities. The stance taken by

these community stalwarts stems partly from their increased awareness but largely it is a strategy to avoid blame and victimization by their communities and the government when childbirth goes wrong. This finding is corroborated by a study in Tanzania which revealed that TBAs were blamed for being the main cause of maternal and neonatal deaths (Pfeiffer & Mwaipopo, 2013).

5.7. Tension between health extension workers and traditional birth attendants

Globally, the transition from TBAs-led to skilled birth attendants led (SBAs-led) delivery has created tension between the two cadres of birth attendants (Sibley & Sipe, 2006; de Vaate, Coleman, Manneh & Walraven, 2002; De Brouwere, Tonglet & Van Lerberghe, 1998; Fleming, 1994). Invariably, this tension has affected the interpretation of the role of TBAs and their integration into community maternity health services worldwide (Kruske & Barclay, 2004). There is a general mood in Girar Jarso woreda that TBAs are gradually losing their esteemed position in society as traditional midwives. In Girar Geber, there was reported tension between HEWs and TBAs regarding the role of the latter in maternity health services in the kebele. HEWs in Girar Geber insisted that TBAs, trained or untrained should refrain from attending childbirth in the kebele. On the other hand, TBAs insisted they were trained and given a mandate by the Ethiopian government to attend childbirth. This confusion has created conflict between HEWs and TBAs in a way that undermines collaboration between the two cadres of birth attendants. The confusion appears to stem from the government's unclear communication about the role of TBAs in community maternity health services delivery in Ethiopia. A similar confusion was reported in Uganda when a strong anti-TBA stance on the part of the government, coupled with lack of any concrete guidelines, presented a challenge to administrators working in

communities where TBAs practise (Rudrum, 2015). In Girar Geber, there appears to be top-down communication process between HEWs and TBAs. The former assert formal authority while the latter push back with traditional power. The mood is different in Adisge, the other study kebele in Girar Jarso woreda. In Adisge, HEWs and TBAs collaborate in identifying pregnant women and/or attending childbirth. There is mutual respect between the two cadres of birth attendants which promotes team-work. Unlike Girar Geber where TBAs may hide and attend childbirth, TBAs in Adisge may refer laboring women to HEWs in the health post or summon them to assist with precipitous home birth. Although HEWs and TBAs in Adisge and Girar Geber recognize the importance of their collaboration to pregnant and birthing women's health and safety, it is unclear why there is no real effort to achieve this level of camaraderie between the cadres in Girar Geber kebele. A stronger collaboration between HEWs, TBAs and WDAs (women development armies)[35] has the potential to boost institutional birth as these cadres have kinship relationship with community women and could influence their childbirth decisions. Other studies revealed that in Samoa and Malaysia nurse-midwives and TBAs are working together in a successful model based on collaboration and true partnership in which there is mutual and genuine respect for each other's skills and practices (Kruske & Barclay, 2004; Koblinski, Conroy, Kureshy, Stanton et al, 2000; WHO, 2000).

5.8. Status of Traditional birth attendants

It was remarkable to learn from participants that most husbands are encouraging their wives to birth in health facilities. Husbands are demanding that TBAs refer their laboring wives

[35] Women development armies is a group of volunteer women assisting health extension workers in the delivery of maternal health care in rural settings of Ethiopia.

to health institutions rather than assisting them to birth at home. A similar finding was reported elsewhere in Ethiopia (Gebrehiwot, Goicolea, Edin & Sebastian, 2012). The Ethiopian government's awareness creation efforts regarding institutional birth is gaining acceptance among men and women in Girar Jarso woreda. Overall, the role of TBAs in Girar Jarso woreda is in flux and these traditional icons are gradually losing stature as traditional midwives in their kebeles. Nonetheless, a few women revere TBAs and seek their assistance during childbirth. TBAs appeared to be vanguards of women's health during childbirth. They sometimes asserted their traditional authority to force women to birth at home when they thought it was safe to do so. Occasionally, they exercised the same authority to ensure that women experiencing complicated labor are transferred to health institutions for safe childbirth. This is a contradictory finding to a study in South central Ethiopia where participants reported incidents at which laboring mothers were retained by TBAs even after complications developed (Roro, Hassen, Lemma, Gebreyesus et al (2014). This study suggests TBAs' ability to exert authority during childbirth is a reflection of the honored position they hold in society. Although TBAs may lose their prestige as birth attendants, they are still respected as cultural and traditional icons in Girar Jarso woreda and Ethiopia. This finding is consistent with a study conducted in Afar region, Ethiopia that revealed that trained traditional birth attendants are highly respected in their communities and women tell them all their secrets (Temesgen, Umer, Buda & Haregu, 2012). While TBAs struggle to save their profession and position in society in the face of government's effort to marginalize them by placing HEWs in the center of kebele maternity health services delivery, many TBAs are at the same time volunteering and supporting the efforts of HEWs to increase institutional birth. Despite systemic alienation, TBAs continue to

make significant contributions to the grand effort to improve Ethiopia's maternal, newborn and child health. It is however important to mention that some TBAs do not have confidence in HEWs midwifery skills. As a result, these TBAs directly refer laboring women to health centers or hospitals and by-pass the HEWs at the health posts. Other TBAs refer laboring women to health posts with the belief that HEWs will forward refer women with childbirth complications to health centers or hospitals. This practice complicates the job of clarifying community referral protocols in Girar Jarso woreda. TBAs referral is documented in other studies (Rudrum, 2015; Warren, 2010).

HEWs in the study were aware that some community residents were not confident in their midwifery skills. To those community members (including TBAs), the HEWs had advised they should feel free to refer laboring women directly to health centers or hospitals. This arrangement has created harmony between TBAs and HEWs (especially in Adisge kebele) and increased direct referral of women to health centers and hospitals during childbirth. There is a need for the Ethiopian government to re-work the role of TBAs given their socio-cultural significance at childbirth. This will eliminate role confusion and potential animosity between TBAs and HEWs in the community midwifery services delivery. Importantly, while most TBAs do not have formal training, they had been at forefront of kebele traditional midwifery services delivery prior to the introduction of health extension workers. Therefore, any state effort to denigrate their contribution will be seen by citizens as ingratitude.

5.9. Religion, Culture and Authority

Religion, culture and authority exert tremendous influence on birthing decisions in Girar Jarso woreda. Some women in this study adhered to religious convictions that God and Saint

Mary (mother of Jesus Christ) had the authority to decide where a woman births. These women did not make birth plans and often wound up with home birth. They relied on faith in the divine and trusted the outcome of childbirth is ordained by God and/or Saint Mary. Therefore, deeply religious women relied on divine power to determine where they birthed and who participated in their childbirth. This disposition put many women at risk during childbirth as they ended up with precipitous labor. As a result, some women birthed unassisted; others birthed by roadside or died due to childbirth complications. All these incidents occurred despite participants' acknowledgment that women who make preparations during pregnancy usually have good childbirth experiences. This contradicts the finding of a study in Western Ethiopia where majority of pregnant women accurately reported their estimated delivery day and had planned to birth at hospital (Ballard, Gari, Mosisa & Wright, 2013). In contrast, most women in this study expressed desire to birth in health facilities but had no concrete birth plans nor knew their due dates. There was a general belief amongst most participants that even the outcome of institutional birth is ordained by divine powers. Most women in the study see health professionals as playing an accessory role in childbirth. The women believed the authoritative birth attendants are God and Saint Mary. Other studies reported that religion and culture influence childbirth decisions (Mekonnen & Mekonnen, 2003; Kaphle, Hancock & Newman, 2013). Most traditional women preferred to birth at home with assistance of family, friends and other community members. However, some women expressed their objection to cultural norms that permitted community members to attend childbirth uninvited. Those women felt a birthing woman should have the right to choose who attends her childbirth. Notwithstanding, the majority of women in the study cited communal support, cultural practices and comfort as

the reasons for home birth in Girar Jarso woreda. On a whole, women cherished cultural food, dancing, singing, prayers and other rituals associated with home birth. However, most women in the study conceded they would opt for institutional birth to save their lives and the lives of their infants.

The Ethiopian government's institutional birth thrust appears to be a top-down initiative introduced to achieve millennium development goals 4 and 5. Although the initiative is commendable, this study suggests that it would have been more impactful if it was implemented with a serious consideration to cultural norms in Ethiopia and involvement of grassroots community leaders. For example, the transition from home-based skilled delivery to institutional delivery program in Bangladesh was successful because of door-to-door community education, introduction of pregnant women and accompanying parties to delivery rooms and available instruments and involvement of community leaders in the rollout communication process (Blum, Sharmin & Ronsmans, 2006). It appears the Ethiopian government's institutional birth campaign was conceptualized without attention to a framework for integrating traditional birthing practices. Many women in Girar Jarso woreda would birth in health institutions where safety and traditional birthing norms converge. This sentiment was evident in women's expression of their confidence in the safety of institutional birth, and gratitude for cultural foods and coffee ceremonies during childbirth in health facilities. This finding is corroborated by a study conducted in Ethiopia which revealed that poor meal quality had negative impact on satisfaction levels of women in labor and delivery unit at Gandhi Memorial Hospital (Melese et al, 2014).

5.10. Preference for and Access to HEWs at kebele level

Although women in the study may birth in health centers or hospitals, most women preferred to birth with HEWs at the health posts in their kebeles. Women feel comfortable to birth with HEWs with whom they have kinship relationship and common culture. Unfortunately, women's wish to birth at health posts is often shattered as some HEWs lack adequate skills to support childbirth or may not be available to assist laboring women due to their house-to-house visits. An Ethiopian study reported that lack of material resources and shortages of trained personnel constrain midwifery services as women and their families are often referred elsewhere when the nearest health facilities are ill-equipped to deal with their problems (Warren, 2010). Health extension workers in the study spoke about their work-overload and inadequate pre-service midwifery training. The twin barriers (work-overload and inadequate training) thwart HEWs effort to provide competent community midwifery health services in the study kebeles. Another colossal obstacle to maternity health services delivery in the study areas is the lack of accommodation for HEWs at health posts. HEWs in the study reside in Fiche and commute to their respective health posts. This living arrangement has resulted in HEWs not being available to assist laboring women at night. Women feared that HEWs' workload and out-of-kebele residence may limit their ability to provide culturally-competent midwifery care for laboring women.

5.11. Birth and Power shifts

Childbirth offers women outlet for rest and temporary power in Girar Jarso woreda. Most women in the study opined that they were exempted from domestic and farm work during pregnancy and 40 or 80 days after childbirth depending on the gender of their infant.

This finding however contradicted my observation of pregnant women working on farms or carrying heavy loads in the study areas. Pregnancy and childbirth elevate a woman's status in Girar Jarso woreda as husbands and family members respond favorably to the woman's wishes during these periods. Women spoke about their husbands' care and attentiveness to their needs during pregnancy and childbirth. Some women manage to get their husbands to see them as equal partners in marriage during pregnancy and postpartum. However, women recalled when the novelty of being a new mother wore off; they found themselves back in subjugated positions to their husbands. This finding suggests that patriarchy and power are unresolvable issues that impact women's experiences and perceptions of childbirth in Girar Jarso woreda. Although the moments of social parity with their husbands may be brief, women spoke about them as part of their pleasant memorable childbirth experiences. The notion of women's temporary ascendancy during pregnancy and childbirth in Girar Jarso woreda fizzles in the face of established traditions as third parties (including TBAs, mothers and grand-mothers) and communities usually make childbirth decisions in the woreda. Women in the study valued their ability to exercise control during home birth. When women birth at home they are able to tell birth attendants about their wishes. A similar finding was reported by another study in Ethiopia (Warren, 2010). Unfortunately, this right is reportedly taken away by health professionals when women birth in health institutions. Most women in the study expressed their desire to birth in health facilities but also expressed apprehension about the controlling nature of health professionals. Women's fear of losing control over their childbirth in health facilities has been reported by other studies (Jouhki, 2012; Lindgren, Radestad, Christensson, Wally-Bystrom et al, 2010). I believe that if women felt that their wishes would be respected by

health professionals, they would be more inclined to birth in health institutions. In their study, King et al (2015) asserted that health services should aim to portray characteristics of trustworthiness, professionalism, customer friendliness, building respectful, harmonious and equitable relationships with women in order to increase institutional birth.

Most women in this study faced opposition from their husbands and elderly women in exercising their reproductive health rights. Because of opposition, some women were not able to make joint decisions about family planning with their husbands. Those women secretly approached HEWs for contraceptives. This secrecy raised suspicion amongst husbands that HEWs were sterilizing their wives through family planning program. Elderly women in this study were of the opinion that younger women were using contraceptives to avoid their social obligation to procreate. Woldemicael and Tenkorang (2010) asserted that traditional family laws in Ethiopia restrict the right of women to regulate their fertility and discourage the use of modern birth control methods. Against this background, it is important for the Ethiopian government and health professionals to realize that programs that run counter to established social norms and traditions are likely to face opposition.

The preceding discussion and interpretations reveal that childbirth in Girar Jarso woreda occurs within complex intersecting contexts. Decisions about where women birth and/or who attends to their childbirth is a kaleidoscope which can only be interpreted with multiple lenses. While no two childbirths are the same, some of the women in the study told childbirth stories and shared experiences that were quite similar. Although women generally had favorable perceptions of the current context in which they live and birth, their perceptions sometimes differed in relation to home versus institutional birth. Nonetheless, irrespective of where

women birthed; they valued safe childbirth, control of the birthing experience and healthy babies. Women in this study opined the joy of bonding with their newborns helped them to forget about the pain and complications of childbirth quickly. The findings of this study suggest one cannot fully understand women's birthing choices in Girar Jarso woreda by overlooking the realities in which women live and birth. The complex childbirth decision-making process, socio-cultural forces, structural and economic factors, personal factors and governmental initiatives were revealed by the study to impact women's experiences and perception of childbirth in Girar Jarso woreda. Against this background, I would like to make the following assertions: Firstly, any commentary on childbirth in Girar Jarso woreda should be grounded in the context in which it occurs. Secondly, it is important to know that childbirth in Girar Jarso woreda is evolving with time against established traditional and cultural birthing norms as more women are birthing in the health system. Thirdly, women's experiences and perceptions of childbirth in Girar Jarso woreda vary.

5.12. Conclusion

In this chapter I provided a brief history of childbirth in Ethiopia which laid the foundation for discussion and interpretations of the study findings. I also presented the rationale for framing this study's findings in social constructionist epistemological lens for analysis and interpretation. In addition, I reiterated in this chapter the study purpose and data collection approaches used and presented succinct discussion and interpretations of study findings. Further, I presented in this chapter barriers and facilitators of institutional birth, the importance of transportation during childbirth, and women's perceptions of home and institutional birth in Girar Jarso woreda. In this chapter, I elucidated the tensions between

HEWs and TBAs in the delivery of community maternity health services, the role of religion, culture and authority in childbirth as well as the use of birth plans amongst women in Girar Jarso woreda. Also in this chapter I discussed women's preference for HEWs and power shifts associated with childbirth in Girar Jarso woreda. Finally, I concluded this chapter with three summary assertions about childbirth in Girar Jarso woreda.

Chapter 6: Conclusion

6.1. General overview

This research was conducted with overarching purpose of understanding the local contexts, women's experiences and perceptions of childbirth in Girar Jarso woreda of Ethiopia. As a researcher, it is my hope that the study findings will be useful in informing efforts to improve maternal, newborn and child health in Ethiopia. The case study was conducted in two rural kebeles (Adisge and Girar Geber) in the Oromiya region of Ethiopia. The study was timely as it was conducted in a period the Ethiopian government and the global health community are aggressively seeking ways to improve women's access to reproductive health services in order to reduce maternal, newborn and child mortalities.

Based on the findings of this study, it can be concluded that improvements are taking place in the conditions in which women live and birth in Girar Jarso woreda. Prominent amongst these improvements are the health extension program, women's increasing awareness about institutional birth, availability of ambulance service, access to health posts, health centers and hospitals (albeit with difficulties). However, the study revealed that the full benefits of these changes to women are tempered by complex decision-making process, cultural preferences, distance, unreliable transportation, road condition, and economic barriers. With regards to decision-making, the study revealed that encouraging pattern is emerging as most laboring women, grandmothers and TBAs in Girar Jarso woreda are asserting themselves to promote safe birth in health institutions. Albeit, women's self-determination in matters regarding their reproductive health is largely restricted by Ethiopia's patriarchal and social norms. Women continue to be subjugated in Girar Jarso woreda and the rest of Ethiopia.

Women's human rights advocacy and policy adoption have failed to trickle down to the core of Ethiopian society. The marginalization of women in major household decisions continue to plague Ethiopia and many other African countries. This was revealed by women's frequent reference to men as decision-makers in their households. Overall, women's powerlessness, physical and economic living conditions characterize their birthing choices in Girar Jarso woreda. A sustained collaboration between HEWs, TBAs, WDAs (women development armies) has shown the potential to improve community maternity services delivery in Girar Jarso woreda. This study revealed that since the inception of the HEP, women are developing interest in institutional birth and sharing their experiences with others in their communities. Despite the emerging uptake of institutional birth in the woreda, the rate is low and varied across socio-demographic strata. Women's stories suggested educated, young and economically-endowed women are more likely to birth in health institutions than their counterparts in Girar Jarso woreda. For many women in Girar Jarso woreda, childbirth is shrouded in uncertainty and often with challenges.

Gaps exist between Ethiopia government's HEP policies and implementation at the community level. The HEP does not give consideration to Ethiopia's socio-cultural norms, women's disempowerment, and health infrastructure and transportation system. These gaps are crucial as they undermine government's efforts to encourage institutional birth to reduce maternal, newborn and child mortalities. This was evidenced in this study by women's frequent reference to socio-cultural, power, and infrastructural barriers they encountered during childbirth. There are weaknesses in the HEP's reproductive health education program at the community level. This was evidenced by lack of active involvement of men and community

leaders in the dissemination and uptake of reproductive health information. The HEP focuses mainly on women in reproductive age with little or no consideration for their husbands/ partners, grandmothers, mothers-in-law, and community leaders even though it is a well-established fact that husbands, grandmothers, mothers-in-law and community leaders are the dominant decision-makers during childbirth in Ethiopia. It is imperative that inclusion of men in reproductive health should proceed in a way that it does not render women powerless in the process. Another crucial gap in the HEP relates to the training and skills capacity of HEWs in Ethiopia. HEWs in this study alluded to their insufficient midwifery training and poor skills set which hindered their ability to handle complicated childbirth. In addition, health posts in the study areas are under-resourced. This situation further complicates the delivery of maternity health services in the research kebeles. Unrealistic workloads of HEWs in Girar Jarso woreda which allows them to spend only 25% of their working hours at health posts and 75% of the time in the field doing house-to-house visits limits their access to laboring women. Overall, women in Girar Jarso woreda continue to exhibit resilience during childbirth despite multiple contextual tensions affecting their childbirth wishes and decisions. Given the extent of socio-cultural, environmental, political, personal, and infrastructural contextual influences on childbirth in Girar Jarso woreda; and given the government of Ethiopia's interest in improving maternal and child health indicators nationwide, I present a set of recommendations in Section 6.2 for consideration.

6.2. Future Direction and Recommendations

Given this case study's collaboration with Ethio-Canada Maternal, Newborn and Child Health Project and the interest shown in this research by Ethiopian health-policy makers,

frontline health workers, mothers, TBAs, grandmothers and community leaders, I would like to make recommendations to boost the current interest and drive to improve maternal, newborn and child health in Oromiya region and Ethiopia. To improve the birthing experiences of women in Oromiya region and Ethiopia, it is imperative for the government and other stakeholders to be aware of the socio-cultural, structural and systemic pitfalls that thwart the provision and uptake of efficient maternity services. A clearer understanding of the importance of rights-based approach to reproductive health services delivery and uptake in Ethiopia is required. Intersectoral approach that brings government, development organizations, communities, the private sector and civil society around issues that affect women's childbirth is required to improve women's living and birthing contexts in Ethiopia. Such collaborations will create unity of purpose, opportunities to mobilize resources for maternal health programs and/or projects that are culturally-sensitive and accessible to women. Within the context of the Sustainable Development Goals (SDGs), current and future maternal and child health programs in Ethiopia must build on the progress made by the MDGs. Ethiopian government needs to conduct comprehensive assessment of its MDGs 4 and 5 programs to identify improvements made, missed targets and opportunities for introducing sustainable initiatives to mitigate maternal and child deaths. The implementation of the recommendations of this dissertation will yield positive outcomes if they are aligned with the sustainable development goals. In implementing this study's recommendations, Ethiopian government and other stakeholders must pay attention to economic and social deprivation, gender and power relations, distribution of health infrastructure and accessibility, and cultural norms that intersect to determine where women birth and who attends their childbirth in Ethiopia. Further, there is a need for research

to explore why some health extension workers are reluctant to collaborate with traditional birth attendants to provide maternal health services in rural areas of Ethiopia. Against this background, this study makes the following recommendations to ensure timely, well-coordinated and culturally-congruent maternity health services delivery and uptake in Girar Jarso woreda and the rest of Ethiopia.

1. Establish a mechanism to clearly communicate government's reproductive rights policy, maternity user fees abolition in public health centers and the role of TBAs to grassroots citizens.
2. Involve husbands/partners, community leaders, TBAs, WDAs, grandmothers, and mothers-in-law in maternity health education and health promotion programs at the kebele level.
3. Encourage integration of traditional childbirth practices into modern obstetric services in the health system (e. g. placenta packaging, coffee ceremony, allow a few family members and friends of laboring women into delivery rooms, allow traditional birthing positions).
4. Deploy midwives to health posts to augment the services of HEWs. HEWs could concentrate on house-to-house visits while midwives stay at the health posts to attend to pregnant and laboring women.
5. Consideration should be given to resourcing health posts, strengthening skills capacity of HEWs, reducing their workload through task sharing and increasing their overall working conditions.
6. Consideration should be given to strengthening community referral system by introducing motorbike ambulance services to augment conventional ambulance services in the woredas.
7. It will be useful to intensify and target education about the importance of birth plans to women, their husbands/partners, other family members and TBAs.
8. Encourage research that explores experiences and perceptions of men, younger women, health professionals and community leaders about childbirth in Ethiopia.

6.3. Implementation issues

The implementation of the recommendations in Section 6.2 may present several challenges. Notable among them are socio-cultural, financial, acceptance, infrastructural issues, and concerns about entrenched patriarchal and power differences that affect women's reproductive health negatively. In this section, I illuminate some of the potential barriers and/or challenges to the implementation of my recommendations.

1. Framing and communicating women's reproductive right as human right may engender opposition from men in patriarchal Ethiopia. Advocating women's reproductive human right opposes established and generally accepted gender relations in Ethiopia.
2. Involving husbands and community leaders (usually men) in maternity health education and health promotion programs may entrench perennial subjugation of women and silence their voices in childbirth decision-making in Ethiopia. Husbands may assert greater decision-making power and authority over their wives' reproductive health.
3. Integrating traditional birthing practices into cosmopolitan obstetrics may require retrofitting of health facilities and staff training. The process may be slow, costly and divert clinical time away from patient care. It may be difficult to meet diverse birthing preferences of women in multi-ethnic society. There may be potential conflict between health professionals and traditional birth attendants who may accompany laboring women to delivery rooms. The conflict may be borne out of differences in practice models of health professionals and traditional birth attendants.

4. Newly deployed midwives to rural settings may face housing problems if they have to relocate to their service kebeles. Women may not be willing to birth with midwives who come from different kebeles. Health posts may lack the resources required for midwives to support pregnant, laboring and postpartum mothers and their babies.
5. Resourcing health posts and strengthening skills capacity of health extension workers may require substantial material and financial investment. Budgets may be piece-meal and stifling.
6. Introducing a fleet of Motorbike ambulances in Ethiopian public health system may require a huge capital outlay. Fuel and maintenance cost for Motorbike ambulances may be substantial and cause diversion of financial resources from other sectors in the economy. There is a potential for misuse of Motorbike ambulances for personal or private purposes.
7. Birth plans may not improve women's childbirth experiences if community maternal- referral system is weak and waiting rooms are not available at health facilities for pregnant women. There may be limited interest to explore the perceptions of men and community leaders about childbirth in Ethiopia. It may be difficult to fund research that explores the perceptions of men and community leaders about childbirth. There is a potential for research to entrench existing traditional childbirth decision-making in Ethiopia which privileges men and community leaders over women.

6.4. Final thoughts

This case study experience has ignited passion in me to pursue a long career in global health research. The affection, support and encouragement I received throughout this research journey from families, friends, acquaintances and health professionals in Ethiopia was electrifying. The gentle smiles on the faces of children, mothers, elderly men and women, community leaders and the rural women in Adisge and Girar Geber who participated in this study are memories I will cherish for the rest of my life. Memories of the picturesque rugged mountainous terrain of Girar Jarso woreda, the view of majestic Sefa river valley in Adisge and pristine landscape of Girar Geber are indelibly embedded in my mind. For the challenges I encountered in the field, I will consider them badges of honor that will launch my career as a budding global health researcher. It is my sincere hope that this research will contribute in a small way to efforts to improving the birthing conditions of women in Ethiopia for generations.

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Appendices

Appendix A: Training manuals
Study title: Birthing in Girar Jarso woreda of Ethiopia

Purpose of the manuals: The manuals were developed to inform health extension workers, research assistants and transcriber/translator about the study purpose and objectives, protocol, roles and expectations. Separate manuals were developed to reflect my varying expectations from health extension workers, research assistants and transcriber/translator.

Schedule 1: Training manual for health extension workers

Content of training manual for health extension workers

1. Brief background of the study purpose and objectives, approval and support letters from University of Saskatchewan, Oromiya Health Bureau, North Shoa Zonal Health Bureau and Girar Jarso Woreda Health Administration
2. Ethical concerns
    - Approach kebele leaders and explain the purpose and objectives of the study to them
    - Seek permission from kebele leaders to recruit potential participants
    - Use invitation letters to invite potential participants for the study
    - Explain the purpose and objectives of the study to potential participants
    - Explain the expectations of the researcher from study participants
    - Discuss the content of invitation letter with potential participants and answer their questions about the study. Leave a copy of invitation letter with each woman you approach
    - Do not coerce women to agree to participate in the study

3. Others
    - Adhere to the inclusion and exclusion criteria given to you
    - Invitees will be screened to determine their suitability for inclusion in the study
    - Inform potential participants about honorarium that they will receive after they have agreed to participate in the study

Schedule 2: Training manual for research assistants

Content of training manual for research assistants

1. Detailed description of study purpose and objectives

2. Importance of ethical and professional conduct in research (privacy and confidentiality were discussed extensively)
3. Develop rapport with participants and clearly explain to them the study purpose & objectives and consent form before the start of each interview
4. Emphasized the importance of respect for study participants
5. The need for attentive ears, good observational skills, punctuality and reliability as a research assistant
6. The importance of asking questions verbatim from interview guides (However, feel free to modify questions to suit the understanding of participants. Extreme care must be taken to ensure that modified questions do not lose their original intent)
7. Ask follow-up questions when necessary
8. Ensure that participants fully understand the consent form before written or oral consent is obtained from them
9. Encourage participants to express any concerns they may have before or during interviews
10. Join me to welcome participants and thank them at the end of each interview

Schedule 3: Training manual for transcriber/translator

Content of training manual for transcriber/translator

1. Detailed description of study purpose and objectives
2. Emphasized the importance of transcribing interviews verbatim from voice to Amharic or Oromic (Afaan Oromo) and then translate them verbatim from the local language to English language
3. Keep all research materials in your possession confidential (audio-recorded interviews, transcripts, emails)
4. Do not discuss the content of audio-taped interviews or transcripts with anyone without my approval
5. Periodically, you, myself and the research assistant will review interview transcripts against audio-tapes to ensure consistency and quality of data
6. At the end of the study you will return to me all audio-recorders with recorded interviews intact. You will delete all email correspondence between you and I that contain information regarding the study
7. At the end of the study you will sign transcript release form from University of Saskatchewan. Please be informed that you will be bound by every word in the transcript release form that you sign

Appendix B: Ethical clearance certificates and support letters

Schedule 1

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	Beh #
Lori Hanson	Community Health and Epidemiology	13-404

INSTITUTION (S) WHERE RESEARCH WILL BE CONDUCTED

Ethiopia

STUDENT RESEARCHER(S)

Enoch Pambour

FUNDER(S)

UNIVERSITY OF SASKATCHEWAN - DEPARTMENT OF COMMUNITY HEALTH AND EPIDEMIOLOGY

TITLE:

Birthing in Girar Jarso Woreda of Ethiopia

ORIGINAL REVIEW DATE	APPROVAL ON	APPROVAL OF	EXPIRY DATE
22-Dec-2013	09/Jan/2014	Application for Behavioral Research Ethics Review Consent Form (individual) Consent Form (focus group) Consent Form (key informants) Letter of Invitation	08-Jan-2015

Full Board Meeting [ ]

Delegated Review [✓] Expedited Review [ ]

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.usask.ca/research/ethics_review/

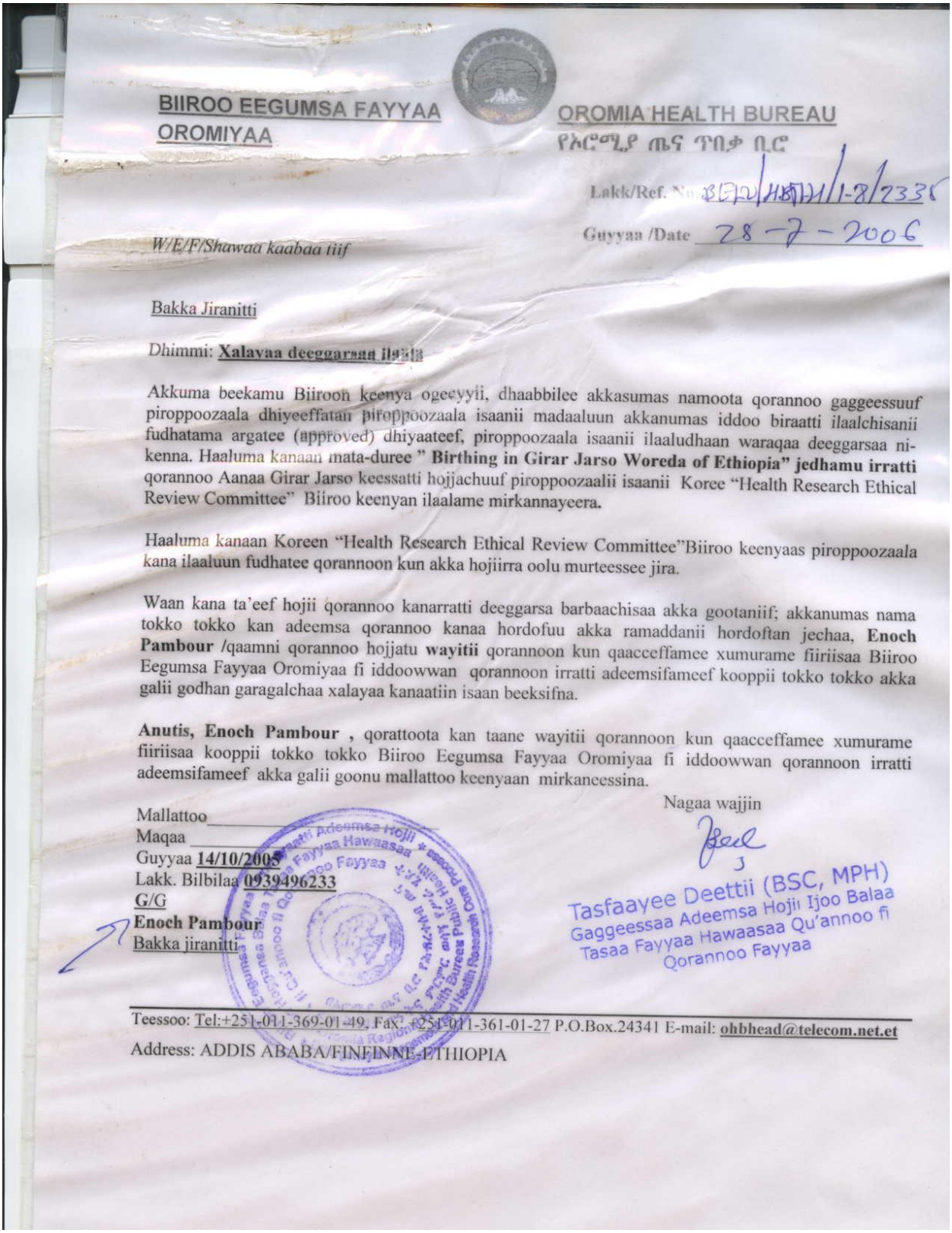
Beth Bilson

Beth Bilson, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon, SK S7N 4J8
Phone: (306) 966-2975 Fax: (306) 966-2069

Schedule 2



BIIROO EEGUMSA FAYYAA OROMIYAA

OROMIA HEALTH BUREAU
የኦሮሚያ ጤና ጥበቃ ቢሮ

Lakk/Ref. No: BTO/HBD/11/1-8/2336

Guyyaa /Date 28-7-2006

W/E/F/Shawaa kaabaa tiif

Bakka Jiranitti

Dhimmi: **Xalayaa deeggarsaa ilaalu**

Akkuma beekamu Biiroon keenya ogeeyyii, dhaabbilee akkasumas namoota qorannoo gaggeessuuf piroppoozaala dhiyeeffatan piroppoozaala isaanii madaaluun akkanumas iddoo biraatti ilaalchisanii fudhatama argatee (approved) dhiyaateef, piroppoozaala isaanii ilaaludhaan waraqaa deeggarsaa ni-kenna. Haaluma kanaan mata-duree " **Birthing in Girar Jarso Woreda of Ethiopia" jedhamu irratti** qorannoo Aanaa Girar Jarso keessatti hojjachuuf piroppoozaalii isaanii Koree "Health Research Ethical Review Committee" Biiroo keenyan ilaalame mirkannayeera.

Haaluma kanaan Koreen "Health Research Ethical Review Committee"Biiroo keenyaas piroppoozaala kana ilaaluun fudhatee qorannoon kun akka hojiirra oolu murteessee jira.

Waan kana ta'eef hojii qorannoo kanarratti deeggarsa barbaachisaa akka gootaniif; akkanumas nama tokko tokko kan adeemsa qorannoo kanaa hordofuu akka ramaddanii hordoftan jechaa, **Enoch Pambour** /qaamni qorannoo hojjatu **wayitii** qorannoon kun qaacceffamee xumurame fiiriisaa Biiroo Eegumsa Fayyaa Oromiyaa fi iddoowwan qorannoon irratti adeemsifameef kooppii tokko tokko akka galii godhan garagalchaa xalayaa kanaatiin isaan beeksifna.

Anutis, Enoch Pambour , qorattoota kan taane wayitii qorannoon kun qaacceffamee xumurame fiiriisaa kooppii tokko tokko Biiroo Eegumsa Fayyaa Oromiyaa fi iddoowwan qorannoon irratti adeemsifameef akka galii goonu mallattoo keenyaan mirkaneessina.

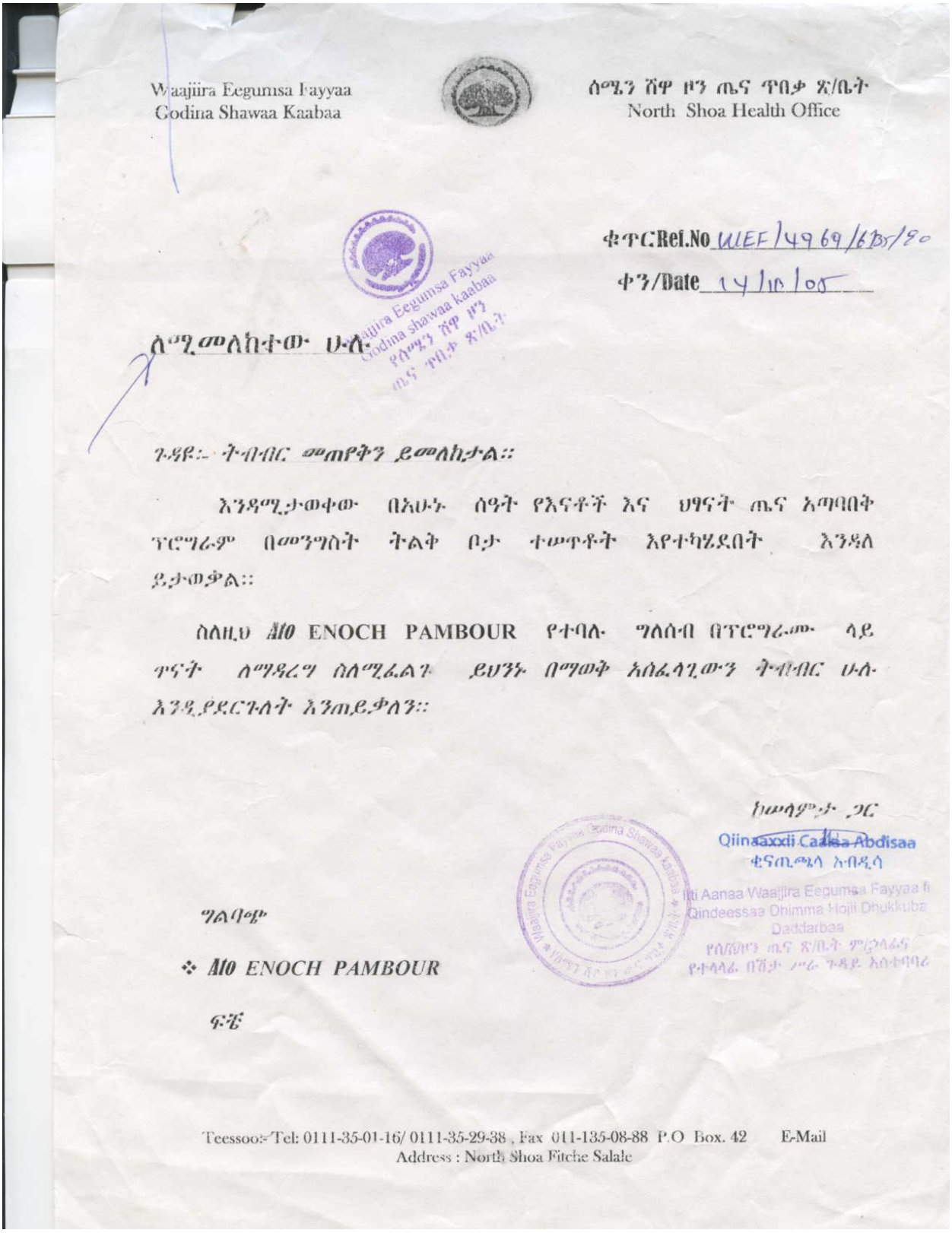
Nagaa wajjin

Mallattoo_____
Maqaa _____
Guyyaa **14/10/2005**
Lakk. Bilbilaa **0939496233**
G/G
Enoch Pambour
Bakka jiranitti

Tasfaayee Deettii (BSC, MPH)
Gaggeessaa Adeemsa Hojii Ijoo Balaa
Tasaa Fayyaa Hawaasaa Qu'annoo fi
Qorannoo Fayyaa

Teessoo: Tel:+251-011-369-01-49, Fax: +251-011-361-01-27 P.O.Box.24341 E-mail: ohbhead@telecom.net.et
Address: ADDIS ABABA/FINFINNE-ETHIOPIA

Schedule 3



Waajjira Eegumsa Fayyaa
Godina Shawaa Kaabaa

ሰሜን ሸዋ ዞን ጤና ጥበቃ ጽ/ቤት
North Shoa Health Office

ቁጥር/Ref.No ሠEF/4969/ፊፀና/80

ቀን/Date 14/10/05

ለሚመለከተው ሁሉ

ጉዳዩ፡- ትብብር መጠየቅን ይመለከታል።

እንዳሚታወቀው በአሁኑ ሰዓት የእናቶች እና ህፃናት ጤና አጣባበቅ ፕሮግራም በመንግስት ትልቅ ቦታ ተሠጥቶት እየተካሄደበት እንዳለ ይታወቃል።

ስለዚህ ዶ/ዐ ENOCH PAMBOUR የተባሉ ግለሰብ በፕሮግራሙ ላይ ጥናት ለማዳረግ ስለሚፈልጉ ይህንኑ በማወቅ አስፈላጊውን ትብብር ሁሉ እንዲያደርጉለት እንጠይቃለን።

ከሠላምታ ጋር

Qiinaaxxii Caalisa Abdisaa
ቂናጢሜላ አብዲሳ

Itti Aanaa Waajjira Eegumsa Fayyaa fi Qindeessaa Dhimma Hojii Dhukkuba Daddarbaa
የስ/ሸዋን ጤና ጽ/ቤት ም/ኃላፊና የተላላፊ በሽታ ሥራ ጉዳይ አስተባባሪ

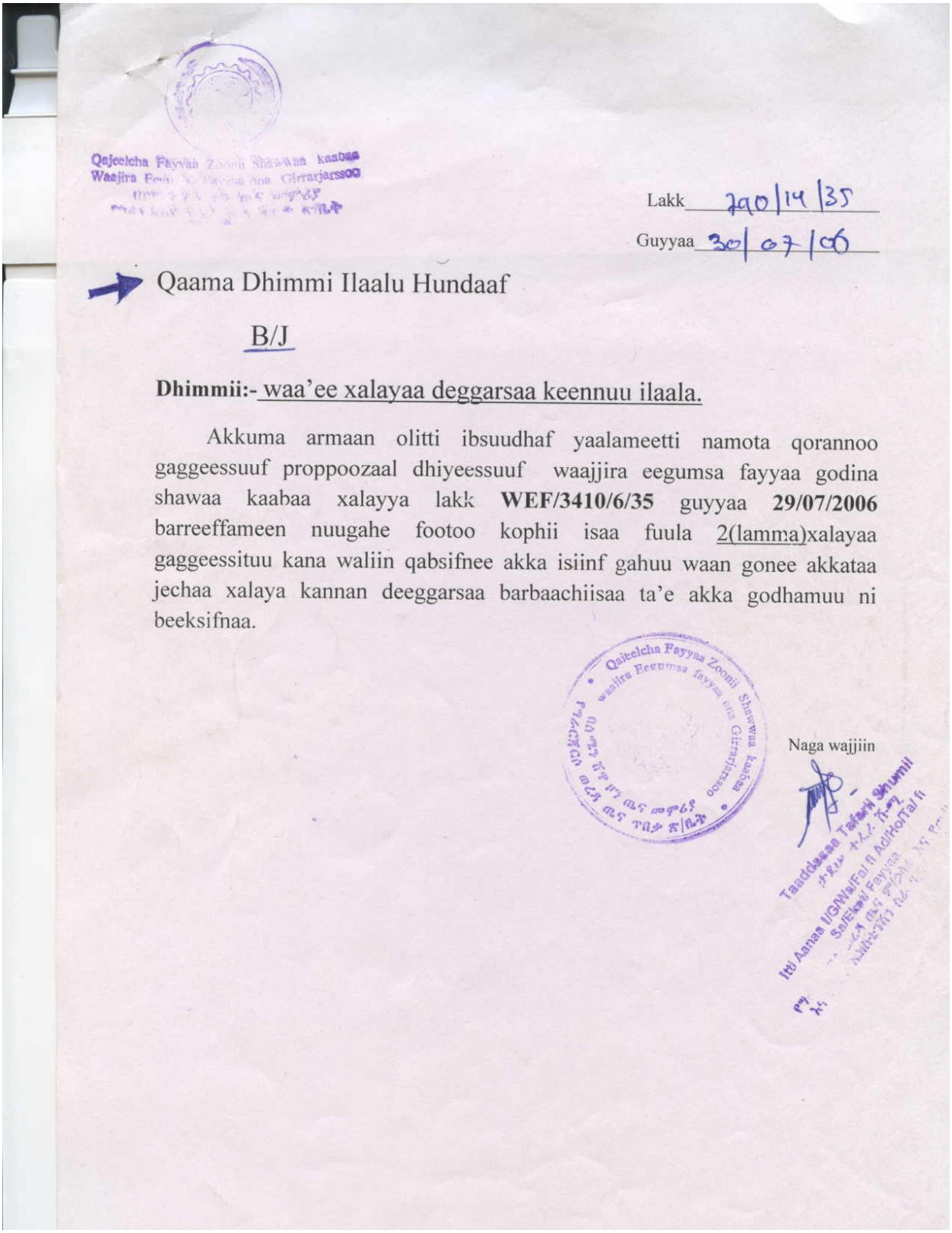
ግልባጭ

❖ ዶ/ዐ ENOCH PAMBOUR

ፍቼ

Teessoo:- Tel: 0111-35-01-16/ 0111-35-29-38 , Fax 011-135-08-88 P.O Box. 42 E-Mail
Address : North Shoa Fitche Salale

Schedule 4



Qajeelcha Fayyaa Zoonii Shawwaa kaabaa
Waajira Eegu[illegible] Fayyaa ana Girrarjarssoo

Lakk 790/14/35

Guyyaa 30/07/06

Qaama Dhimmi Ilaalu Hundaaf

B/J

Dhimmii:- waa'ee xalayaa deggarsaa keennuu ilaala.

Akkuma armaan olitti ibsuudhaf yaalameetti namota qorannoo gaggeessuuf proppoozaal dhiyeessuuf waajjira eegumsa fayyaa godina shawaa kaabaa xalayya lakk **WEF/3410/6/35** guyyaa **29/07/2006** barreeffameen nuugahe footoo kophii isaa fuula 2(lamma)xalayaa gaggeessituu kana waliin qabsifnee akka isiinf gahuu waan gonee akkataa jechaa xalaya kannan deeggarsaa barbaachiisaa ta'e akka godhamuu ni beeksifnaa.

Qajeelcha Fayyaa Zoonii Shawwaa kaabaa
Waajira Eegumsa fayyaa ana Girrarjarssoo

Naga wajjiin

Taaddasaa Tafarii Dhummii
Itti Aanaa I/GWajFal fi AdiHoTaFi

Appendix C: Invitation letters

Schedule 1

Letter of Invitation to Traditional Birth Attendants, Health Extension Workers and Grandmothers (Key informants)

Student name: Enoch Pambour

Supervisor: Dr. Lori Hanson, Department of Community Health and Epidemiology, Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca

Project title: Birthing in Girar Jarso woreda of Ethiopia

Dear Madam:

I am Enoch Pambour, a student from University of Saskatchewan in Canada. I am pleased to invite you to take part in my doctoral research study entitled "Birthing in Girar Jarso woreda of Ethiopia". This study wants to find out how women feel about having babies in Girar Jarso woreda. I am looking for traditional birth attendants, health extension workers and grandmothers who are willing to share birthing stories with me based on their experiences in supporting birthing women in Girar Jarso woreda. This research study was reviewed and approved on ethical grounds by the University of Saskatchewan's Behavioral Research Ethics Board and Oromiya Health Bureau Health Research Ethical Review Committee.

If you agree to participate, I will come to your house or we can arrange to meet at a place of your choice. I am hoping that we will be able to meet for about two to four hours on one occasion to talk about your birthing experiences.

I plan to report your stories as part of my thesis (a book-like project), and may present parts of your stories in publications or at conferences. I would also share the study findings (including your stories) with the Ethiopian Federal Ministry of Health, North Shoa Zonal Health Bureau, Oromiya Health Bureau, Girar Jarso woreda Administration, Girar Jarso woreda Health Office and Ethio-Canada Maternal, Newborn and Child Health Project. Before we start the interview, we will talk about some ways that we can protect your privacy (if you wish), such as using a false name or changing some of the details of your stories. It is very important that you understand that people who know you or about you may be able to identify you based on what you say. I will always respect your right to choose how your story should be told and will do everything I can to protect your privacy, but I encourage you to carefully think about this before you decide to participate in this study.

If you are interested in learning more about this study, please contact Ato Kinati Chala (Deputy Director of North Shoa Zonal Health Bureau) at (251) 0911-775478. You may tell him that you would like to receive more information and I will call you if you leave your telephone number for me.

Sincerely,

Enoch Pambour

Schedule 2

Letter of Invitation to Women who birthed at home or in the health system

Student name: Enoch Pambour

Supervisor: Dr. Lori Hanson, Department of Community Health and Epidemiology, Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca

Project title: Birthing in Girar Jarso woreda of Ethiopia

Dear Madam:

I am Enoch Pambour, a student from University of Saskatchewan in Canada. I am pleased to invite you to take part in my doctoral research study entitled "Birthing in Girar Jarso woreda of Ethiopia". This study wants to find out how women feel about having babies in Girar Jarso woreda. I am looking for mothers who are willing to share birthing stories with me based on their experiences birthing in Girar Jarso woreda. This research study was reviewed and approved on ethical grounds by the University of Saskatchewan's Behavioral Research Ethics Board and Oromiya Health Bureau Health Research Ethical Review Committee.

If you agree to participate, I will come to your house or we can arrange to meet at a place of your choice. I am hoping that we will be able to meet for about two to four hours on one occasion to talk about your birthing experiences.

I plan to report your stories as part of my thesis (a book-like project), and may present parts of your stories in publications or at conferences. I would also share the study findings (including your stories) with the Ethiopian Federal Ministry of Health, North Shoa Zonal Health Bureau, Oromiya Health Bureau, Girar Jarso woreda Administration, Girar Jarso woreda Health Office and Ethio-Canada Maternal, Newborn and Child Health Project. Before we start the interview, we will talk about some ways that we can protect your privacy (if you wish), such as using a false name or changing some of the details of your stories. It is very important that you understand that people who know you or about you may be able to identify you based on what you say. I will always respect your right to choose how your story should be told and will do everything I can to protect your privacy, but I encourage you to carefully think about this before you decide to participate in this study.

If you are interested in learning more about this study, please contact Ato Kinati Chala (Deputy Director of North Shoa Zonal Health Bureau) at (251) 0911-775478. You may tell him that you would like to receive more information and I will call you if you leave your telephone number for me.

Sincerely,

Enoch Pambour

Schedule 3

Letter of invitation to Traditional birth attendants, health extension workers and grandmother (Amharic).

በጥናቱ ቁልፍ የመረጃ ምንጭ ሆነዉ ለሚሳተፉት የልምድ አዋላጆች የጤና ኤክስቴንሽን ሠራተኞችና አያቶች የተሳትፎ ጥሪ ግብዣ ደብዳቤ

የተማሪ ስም፡- ኢኖክ ፓምቡር

የአማካሪ ስም ፡- ዶ/ር ሎሪ ሀንሰን ሕ/ሰብ ጤናና ኢፒዴሚዮሎጂ ት/ክፍል

ስልክ ቁጥር ፡-306-966-7936

ኢ-ሜይል lori.hanason@usask.ca

የጥናቱ ፕሮጀክት ርዕስ፡- የወሊድ ሁኔታ በግራር ጃርሶ ወረዳ ኢትዮጵያ

የተወደዱ ወ/ሮ፡-

እኔ ኢኖክ ፓምቡር እባላለሁ:: ባሁኑ ወቅት በካናዳ ሃገር በሚገኘዉ የሳስካትቸዋን ዩኒቨርስቲ ተማሪ ነኝ:: "የወሊድ ሁኔታ ጃርሶ ወረዳ" በሚል ርዕስ በሚካሄደዉ የፒኤችዲ ጥናት ተሳታፊ እንዲሆኑ ሰጋብዝዎት እጅግ በጣም ደስ እያለኝ ነዉ:: በዚህ ጥናት እናቶችን ያዋለዱት የልምድ አዋላጆች፣ የጤና ኤክስቴንሽን ሰራተኞችና እናቶች በወረዳዉ የማዋለድ አገልግሎት በመስጠት ሂደት ያካበቱትን ተሞክሮና ልምድ እንዲያካፍሉኝ እፈልጋለሁ::

ይህ ጥናት አስፈላጊዉን የምርምር ሥራ ሂደት ያለፈና ጥናቱ ተግባራዊ እንዲደረግ ተገቢዉን ፈቃድ ከሳስካትቸዋን ዩኒቨርሲቲ የምርምር ስራ አጽዳቂ ቦርድና ከኦሮሚያ ጤና ቢሮ የምርምር አግባብነት አጽዳቂ ቦርድ አግኝቷል::

በዚህ ጥናት ለመሳተፍ የሚስማሙ ከሆነ ቃለ ምልልሱን ለማካሄድ በሚመቸዉ ሁኔታ ከታቸለ ቤትዎ በመምጣት ካልሆነም ሌላ ምቹ ቦታ መርጠን ማከናወን እንችላለን:: የተፈላጊዉን መረጃ አሟልቶ ለማግኘት የቃለ ምልልሱን ሂደት ከ2-4 ሰዓት ሊጠይቀን ይችላል በዚህ ጊዜ ዉስጥ ልጅ ሲወልዱ ያጋጠምዎት ልምድ በስፋት ያካፍሉናል::

ይህ ጥናት ሲጠቃለል የሰጡን የህይወት ልምድ ታሪክዎ በመጻፍ መልክ ተጠርዞ ወይንም በታወቁ የምርምር ሥራ ህትመት ጆርናሎች እንዲሁም በተለያዩ ኮንፍራንሶች በመቅረብ አግባብ ካላቸዉ የሕ/ሰብ ክፍሎች ጋር መረጃዉን እንለዋወጣለን:: በተጨማሪም የጥናቱ ዉጤት የኢፌድሪ የጤና ጥበቃ ሚ/ር፣ የኦሮሚያ ጤ/ቢሮ ፣የሰሜን ሸዋ ዞን ጤና መምሪያ ፣የግራር ጃርሶ ወረዳ አስተዳደር፣ የግራር ጃርሶ ወረዳ ጤ/ጥ/ጽ/ቤትና የኢትዮ-ካናዳ እናቶች ጨቅላ ህጻናትና ህጻናት ፕሮጀክት ጽ/ቤት ሪፖርት ይደረጋል::

ቃለ ምልልሱን ከመጀመራችን አስቀድሞ በቃለ-ምልልሱ አካሄድ ላይ አንዳንድ ጉዳዮችን ማንሳት ተገቢ ነዉ:: በቃለ ምልልሱ ወቅት ሙሉ ነጻነት እንዲሰማዎትና ማንነትዎ እንዳይታወቅ ከፈለጉ በትክክለኛ ስምዎ ፋንታ ጊዜያዊ ስም መጠቀም ቀጥተኛ ታሪክዎን በሌላ ታሪክ በመለወጥ እንዳይታወቅ ለማድረግ ጥረት ይደረጋል:: ሆኖም ግን አጽንኦት ሰጥቼ መግለጽ የምፈልገዉ ነገር ቢኖር በጥናቱ ሂደት የሰጡትን ታሪክ በማንበብ ወይንም በመስማት ምንም እንኳን በበኩሌ ማንነትዎን ለመሸፋን ጥንቃቄ ባደርግም ከታሪኩ ሂደት አኳያ ማንነትዎን ሊረዱ የሚችሉ ሰዎች ሊኖሩ ይችሉ ይሆናል:: ይህን ደግሞ ሙሉ በሙሉ ለመሸፈን አዳጋች ሊሆን ስለሚችል አስቀድሜ ማሳሰብ እፈልጋለሁ:: በመሆኑም በቃለ ምልልሱ ከመሳተፍዎ በፊት ይህንኑ በሚገባ እንዲገነዘቡ በጥሞና አሳሰባለሁ::

ስለ ጥናቱ ሂደት የበለጠ መረዳት ከፈለጉ አቶ ቅናት ጫላ የሰሜን ሸዋ ዞን ጤና መምሪያ ም/ ኃላፊን በስልክ ቁጥር +251-09-11-77-54-78 ማግኘት የሚችሉ መሆኑን አስገነዝባለሁ:: እንዲሁም የግል ስልክ ካላችሁ እኔ ራሴ ደዉዬ ላገኛችሁ እችላለሁ::

ከማክበር ሰላምታ ጋር

ኢኖክ ፓምቡር

Schedule 4

Letter of invitation to Women who birthed at home or in the health system (Amharic).

በቤታቸዉ ወይንም በጤና ተቋማት ልጆቻቸዉን የተገላገሉት እናቶች በጥናቱ ተሳታፊ እንዲሆኑ የግብዣ ደብዳቤ

የተማሪ ስም፡- ኢናኪ ፓምቡር

የአማካሪ ስም ፡- ዶ/ር ሎሪ ሀንሰን ሕ/ሰብ ጤናና ኢፒዴሚዮሎጂ ት/ክፍል

ስልክ ቁጥር ፡-306-966-7936

ኢ-ሜይል lori.hanason@usask.ca

የጥናቱ ፕሮጀክት ርዕስ፡- የወሊድ ሁኔታ በግራር ጃርሶ ወረዳ ኢትዮጵያ

የተወደዱ ወ/ሮ፡-

እኔ ኢናኪ ፓምቡር እባላለሁ:: ባሁኑ ወቅት በካናዳ ሃገር በሚገኘዉ የሳስካችችዋን ዩኒቨርስቲ ተማሪ ነኝ:: “የወሊድ ሁኔታ በጃርሶ ወረዳ” በሚል ርዕስ በሚካሄደዉ የፒኤችዲ ጥናት ተሳታፊ እንዲሆኑ ሰጋብዝዎት እጅግ በጣም ደስ እያለኝ ነዉ:: በዚህ ጥናት በቤታቸዉ ወይንም በጤና ተቋማት ልጆቻቸዉን የተገላገሉት እናቶች ልጆችን በመውለድ ሂደት ያካበቱትን ተሞክሮና ልምድ እንዲያካፍሉኝ እፈልጋለሁ::

ይህ ጥናት አስፈላጊዉን የምርምር ሥራ ሂደት ያለፈና ጥናቱ ተግባራዊ እንዲደረግ ተገቢዉን ፈቃድ ከሳስካችችዋን ዩኒቨርሲቲ የምርምር ስራ አጽዳቂ ቦርድና ከኦሮሚያ ጤና ቢሮ የምርምር አግባብነት አጽዳቂ ቦርድ አግኝቷል::

በዚህ ጥናት ለመሳተፍ የሚስማሙ ከሆነ ቃለ ምልልሱን ለማካሄድ በሚመቸዉ ሁኔታ ከታቸለ ቤትዎ በመምጣት ካልሆነም ሌላ ምቹ ቦታ መርጠን ማከናወን እንችላለን:: የተፈላጊዉን መረጃ አሟልቶ ለማግኘት የቃለ ምልልሱን ሂደት ከ2-4 ሰዓት ሊጠይቀን ይችላል በዚህ ጊዜ ዉስጥ ልጅ ሲወልዱ ያጋጠምዎት ልምድ በስፋት ያካፍሉናል::

ይህ ጥናት ሲጠቃለል የሰጡን የህይወት ልምድ ታሪክዎ በመጻፍ መልክ ተጠርዞ ወይንም በታወቁ የምርምር ሥራ ህትመት ጆርናሎች እንዲሁም በተለያዩ ኮንፍራንሶች በመቅረብ አግባብ ካላቸዉ የሕ/ሰብ ክፍሎች ጋር መረጃዉን እንለዋወጣለን:: በተጨማሪም የጥናቱ ዉጤት የኢፌድሪ የጤና ጥበቃ ሚ/ር፣ የኦሮሚያ ጤ/ቢሮ ፣የሰሜን ሸዋ ዞን ጤና መምሪያ ፣የግራር ጃርሶ ወረዳ አስተዳደር፣ የግራር ጃርሶ ወረዳ ጤ/ጥ/ጽ/ቤትና የኢትዮ-ካናዳ እናቶች ጨቅላ ህጻናትና ህጻናት ፕሮጀክት ጽ/ቤት ሪፖርት ይደረጋል::

ቃለ ምልልሱን ከመጀመራችን አስቀድሞ በቃለ-ምልልሱ አካሄድ ላይ አንዳንድ ጉዳዮችን ማንሳት ተገቢ ነዉ:: በቃለ ምልልሱ ወቅት ሙሉ ነጻነት እንዲሰማዎትና ማንነትዎ እንዳይታወቅ ከፈለጉ በትክክለኛ ስምዎ ፋንታ ጊዜያዊ ስም መጠቀም ቀጥተኛ ታሪክዎን በሌላ ታሪክ በመለወጥ እንዳይታወቅ ለማድረግ ጥረት ይደረጋል:: ሆኖም ግን አጽንኦት ሰጥቼ መግለጽ የምፈልገዉ ነገር ቢኖር በጥናቱ ሂደት የሰጡትን ታሪክ በማንበብ ወይንም በመስማት ምንም እንኳን በበኩሌ ማንነትዎን ለመሸፋን ጥንቃቄ ባደርግም ከታሪኩ ሂደት አኳያ ማንነትዎን ሊረዱ የሚችሉ ሰዎች ሊኖሩ ይችሉ ይሆናል:: ይህን ደግሞ ሙሉ በሙሉ ለመሸፈን አዳጋች ሊሆን ስለሚችል አስቀድሜ ማሳሰብ እፈልጋለሁ:: በመሆኑም በቃለ ምልልሱ ከመሳተፍዎ በፊት ይህንኑ በሚገባ እንዲገነዘቡ በጥሞና አሳሰባለሁ::

ስለ ጥናቱ ሂደት የበለጠ መረዳት ከፈለጉ አቶ ቅናት ጫላ የሰሜን ሸዋ ዞን ጤና መምሪያ ም/ ኃላፊን በስልክ ቁጥር +251-09-11-77-54-78 ማግኘት የሚችሉ መሆኑን አስገነዝባለሁ:: እንዲሁም የግል ስልክ ካላችሁ እኔ ራሴ ደዉዬ ላገኛችሁ እችላለሁ::

ከማክበር ሰላምታ ጋር ኢናኪ ፓምቡር

Appendix D: Interview guides

Schedule 1

Interview guide (Focus group discussion)

1. Tell me about yourself, your family, your work and your village.
2. Tell me about your children.
3. Tell me about how you felt when you gave birth in Girar Jarso woreda.
4. Tell me about what happened when you gave birth in Girar Jarso woreda.
5. Tell me about where your child or children were born and why they were born there.
6. Did you want to give birth to your child where it was born? Explain why yes or no.
7. Who decided where to birth your child?
8. Tell me about the people who helped you when you were giving birth to your child or children.
9. Did you want this person or persons to assist you during childbirth?
10. Tell me about how a decision was made about whom to assist you during childbirth.
11. What did you like about your childbirth?
12. What did you dislike about your childbirth?
13. What do other women say about childbirth in your kebele?
14. Who should make a decision about where you birth your child?
15. Where do you think women should birth and why?
16. Who should decide the person(s) that helps you when you are giving birth?
17. What do you think can be done to make childbirth in your kebele more comfortable and safer?

Schedule 2

Interview guide (Mothers with home birth experience)

1. How long have you lived in this kebele? Prompt: How is life like living in this kebele? How many children do you have? How many people do you have in your family? Are you married? Do you work? Who do you go to when you are sick? What do you think about your health? Do you consider yourself to be in good health? What type of food do you normally eat? Do you change what you eat when you are pregnant?

2. How did it feel to be pregnant? Prompt: Were you happy? Were you sad? What did your husband say when he first found out that you were pregnant? Prompt: Was he happy? Was he sad? Was he angry? Was your husband kind to you when you were pregnant? How did the other adults in your family react to your pregnancy? Prompt: Were they happy? Were they sad? Were they angry? How did the children in your family react to your pregnancy? Did you

talk about where you will birth with anyone before the birth took place? Prompt: Who did you talk to? What did the person(s) say? Did you agree with what the person(s) said?

3. How did it feel like birthing at home? Prompt: Were you scared? Who was there when you gave birth to your child? Was your husband there? Was your mother there? Was your Grandmother there? Was your mother-in-law there? Who helped you when you gave birth to your child? Was it a hard birth? Was your baby healthy? Were you healthy? What happened after the birth? Did you get enough rest? How long? What do you like about home birth? Are there any concerns you have about home birth? When did you restart house work after the birth? How was your health and the baby's health monitored days or weeks after the birth?

4. Who would you like to be present when you are birthing at home? Prompt: Why do you want these people to be present at your childbirth?

5. Have you always birthed at home? Prompt: What do you like about home birth? How is home birth different from health center or hospital birth to you? How comfortable is home birth to you? Who made the decision for you to birth at home? Do you feel pressured to birth at home? Are there any cultural practices you experienced with your home birth? How did you prepare for your home birth? If you get pregnant again will you like to birth at home? Why so? Why not?

6. What do other women say about childbirth in your kebele?

7. What, if anything would you like to see change about birthing at home in your kebele?

Schedule 3

Interview guide (Traditional birth attendants)

1. How long have you been a traditional birth attendant? How did you become a traditional birth attendant? Who did you learn your skills from? How long did it take you to learn to be a traditional birth attendant? Was the training interesting? Was it difficult? Can you describe your job to me? How many births have you attended alone? How many births have you attended with other traditional birth attendants? How many births have you attended with health extension workers? How many births have you referred to the health post or health center? Do you come to the health post or health center with birthing women? How are you invited to the home to support birthing women? Are you invited by the birthing women themselves, their mothers, mothers-in-laws, grandmothers or husbands? Do you get support when you are assisting birthing women in their homes? Who supports you? What type of support do you get? What resources do you have to support birthing women in their homes? What type of support

do you give birthing women in their homes? How do you feel about your work as a traditional birth attendant?

2. How would you describe your relationship with women in this kebele? How do women feel about traditional birth attendants? How do men feel about traditional birth attendants? How does it feel to support birthing women at home? Do you experience any challenges in supporting birthing women at home? What challenges, if any? How do you decide when to refer a woman to the health post or health center? How are women transferred from the home to health post or health center? Do they go by transport? Do they walk? Do you come with women to the health post, health center or hospital when they are in labor? Do you continue care for transferred women at the health post or health center? Are transferred women cared for promptly upon arrival at the health post or health center? Does the health post or health center have sufficient equipment, medicines and staff to support birthing women? Are you satisfied with the support birthing women are receiving at the health post or health center?

3. Why do you think most women choose to birth at home? Why do some women birth at the health post, health center or hospital? What do you know about the health extension workers in this community? What do they do? What do you do that is different from the health extension workers? Why do you think some women birth with health extension workers?

4. How would you describe the type of women who might birth at home? How would you describe the type of women who might birth at the health post, health center or hospital?

5. Is there any interaction between traditional birth attendants and health extension workers in your kebele? How do traditional birth attendants (TBAs) and health extension workers (HEWs) interact? Are they friendly? Can you tell me about a time that they worked together? Can you tell me about a time they disagreed? Tell me about the importance of the relationship between TBAs and HEWs to women's birthing experiences. What do you think might happen if there is a good relationship between them? What do you think might happen if there is a bad relationship between them?

6. Can you tell me about some of the good experiences women have had birthing at home in this kebele? Can you tell me about some of the bad experiences women have had birthing at home in this kebele? Have any women died birthing at home in your kebele? How many do you know about?

7. Tell me about some of the changes that can improve women's home birth experiences in this kebele?

8. Tell me about the challenges women face when they birth at home in your kebele.
9. Where do you think that women should birth and why?
10. What do other women say about childbirth in your kebele?

Schedule 4

Interview Guide (Mothers with Home Birth Experience) /Gaaffi Fi Deebii Haadhota Muxannoo Manatti Dahuu Qaban Waliin Taasfame

1. Ganda (Mandara) kana keessa hammamiif jiraatee? Jireenyi ganda kanaa maal fakkaataa? Ijoollee meeqa qabdaa? Baay'inni maatiikee meeqadha? Hermuteettaa? Hojii ni hojjetaa? Yeroo sidhukkubbu eenyu bira deemtee yalmtaa? Waa'ee fayyaakee maal yaaddaa? Fayyaanke haala gaarii irra jira jettee yaaddaa? Nyaataa gosa akkamiiti nyaattaa? Yeroo ulfa taatu haala nyaatake hinjijjirtaa?

2. Ulfa ta'uu keetti maaltu sitti dhaga'amee? Gammaddee turtee?Gadditee turtee?Abbaan manaakee ulfa ta'uukee yeroo jalqabaaf yommuu beeke maal jedhee? Gammadee turee?Gaddee turee? Aaree turee?Abbaan manaake yeroo ulfake siif yaadaa turee?Namoonni ga'eessonni biroon ulfa ta'uukee akkamitti iaalaa turan?Gammadanii turanii?Gaddanii turanii?Aaranii turanii?Daa'imman maatii kee keessa jiran ulfaa'uukee akkamitti ilaalaa turani? Osoo hin dahiin dura eessatti akka dahuu qabdu namni ati waliin haasofte jiraa?Eenyu waliin haasofte? Namni ati waliin haasofte maal jedhe/jette? Yaada kenname fudhattee?

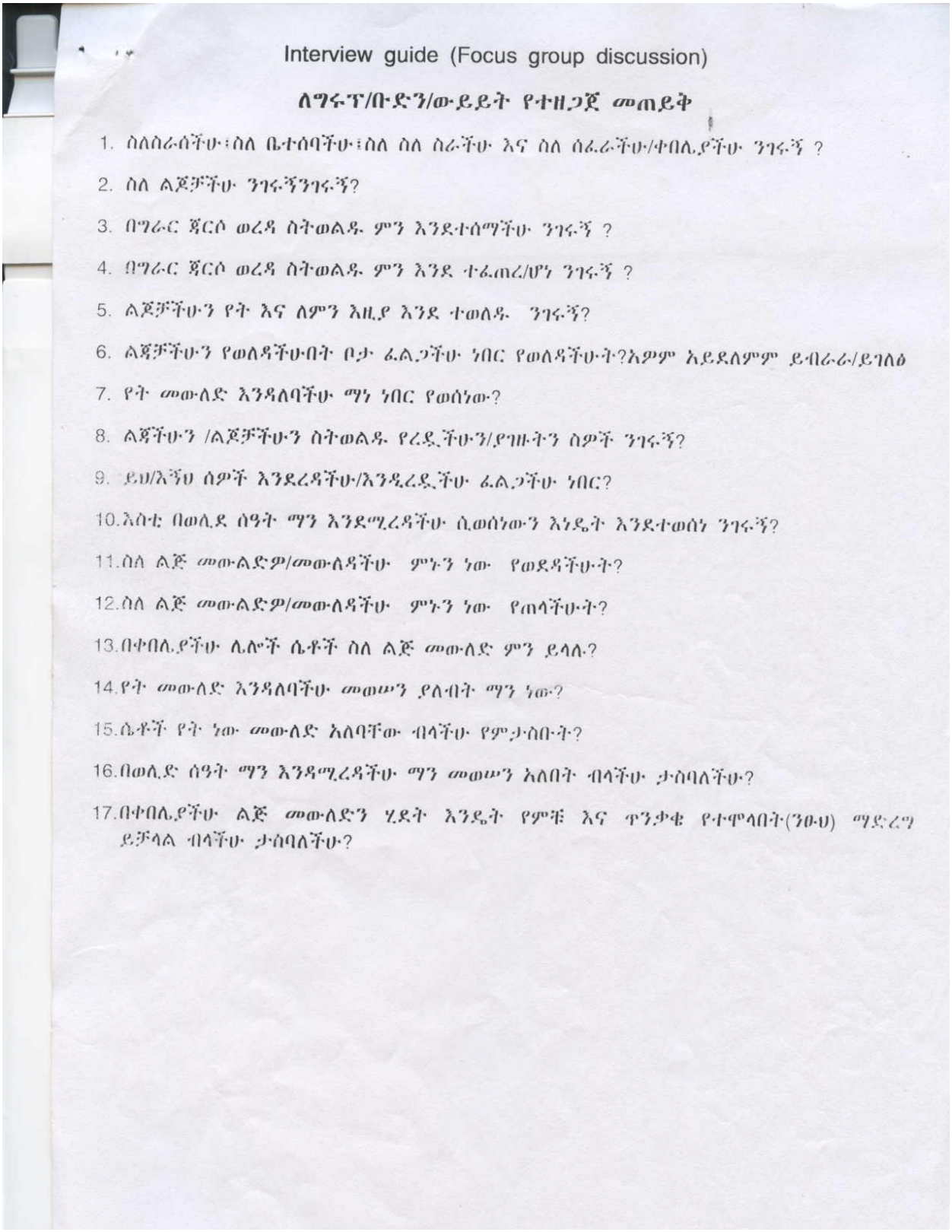
3. Manatti dahuukeetiin maaltu sitti dhaga'amee? Sodaattee turtee? Eenyutu si wajjin turee? Abbaan manaa kee siwaliin turee? Haatike siwaliin turtee? Amaatiinke siwaliin turtee? Akkoon kee achi turtee?Yeroo deessu sitti uulfaatee turee? Daa'imnikee fayyaa turtee? Atihoo fayyaa turtee? Dahuukeetiin booda maaltu raawwatame? Boqonnaa gahaa argattee turtee? Yeroo hammamiif? Manatti dahuu ilaalchisee waanti si yaaddessu jiraa? Deessee booda hojii manaa yoom jalqabdee? Deessee guyyoota yookiin torbeewwan muraasa boooddee fayyaa keetii fi fayyaa daa'imakee eenyutu hordofaa?

4. Mana keessatti yommuu deessu eenyu akka si waliin taa'u barbaaddaa? Namoonni kun yommuu ati deessu akka isaan si waliin taa'ani maaliif barbaaddee?

5. Yeroo hundaa manatti deessaa? Manatti da’uu waliin walqabatee maaltu sitti tolaa? Manatti da’uu fi buufata fayyaatti yookiin hospitaalatti da’uun siif garaagarummaa maalii qabaa? Manatti da’uun siif hangam mijataadhaa? Manatti akka deessu eenyutu siif murteessaa? Manatti akka deessu dhiibbaan sirra gahee turee? Manatti yommuu deessu gochaaleen aadaa si quunnamee jiraa? Manatti yommuu deesse qophii akkamii gochaa turtee? Kana booddee yoo ulfoofte manatti ni deessaa? Maaliif?

6. Manatti dahuu ilaalchisee maaltu akka jijjiiramu barbaaddaa?

Schedule 5: Interview guide for Focus group discussion (Amharic)

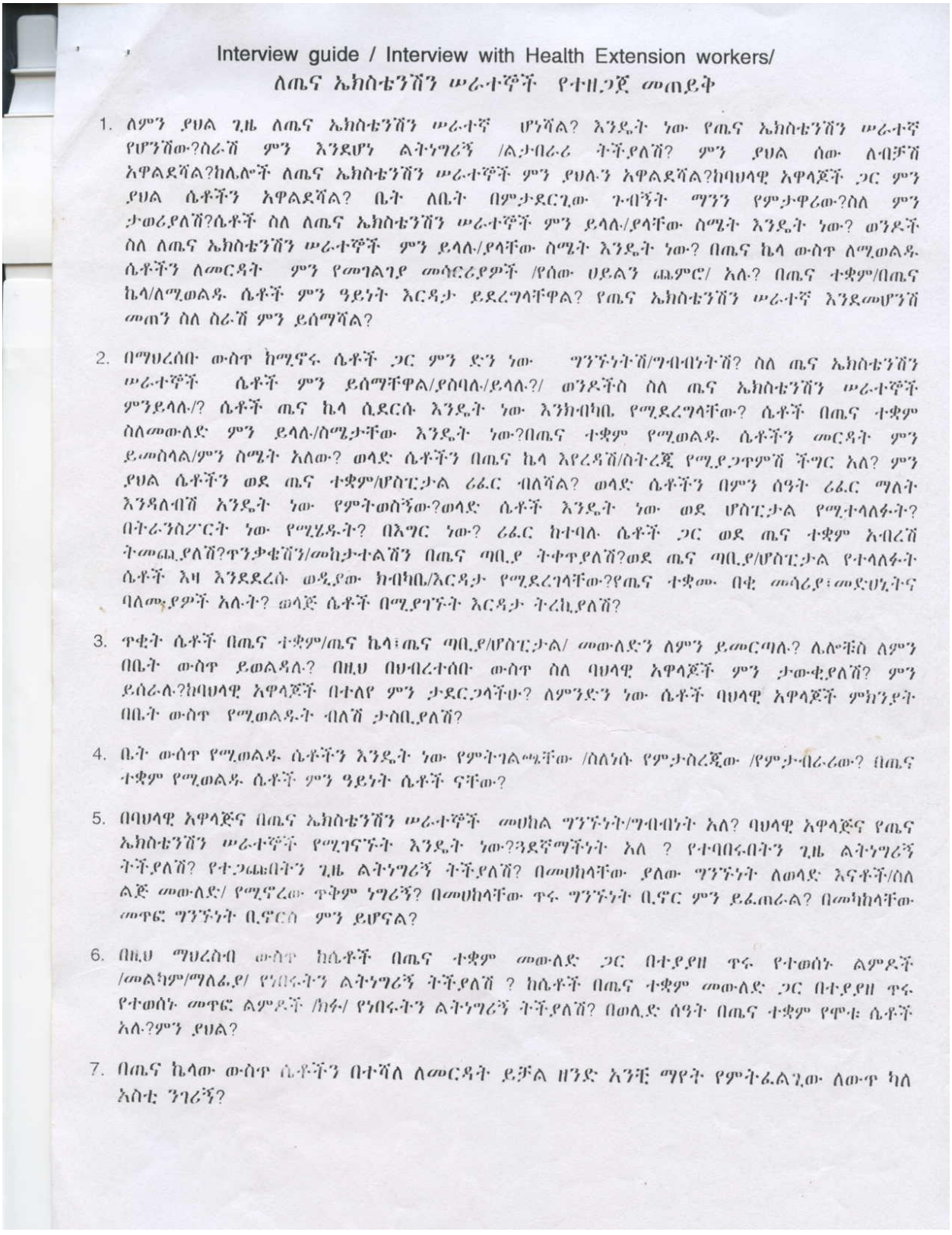


Interview guide (Focus group discussion)

ለግሩፕ/ቡድን/ውይይት የተዘጋጀ መጠይቅ

1. ስለስራሰችሁ፣ስለ ቤተሰባችሁ፣ስለ ስለ ስራችሁ እና ስለ ሰፈራችሁ/ቀበሌያችሁ ንገሩኝ ?
2. ስለ ልጆቻችሁ ንገሩኝንገሩኝ?
3. በግራር ጃርሶ ወረዳ ስትወልዱ ምን እንደተሰማችሁ ንገሩኝ ?
4. በግራር ጃርሶ ወረዳ ስትወልዱ ምን እንደ ተፈጠረ/ሆነ ንገሩኝ ?
5. ልጆቻችሁን የት እና ለምን እዚያ እንደ ተወለዱ ንገሩኝ?
6. ልጃቸችሁን የወለዳችሁበት ቦታ ፈልጋችሁ ነበር የወለዳችሁት?አምም አይደለምም ይብራራ/ይገለፅ
7. የት መውለድ እንዳለባችሁ ማነ ነበር የወሰነው?
8. ልጃችሁን /ልጆቻችሁን ስትወልዱ የረዷችሁን/ያገዙትን ሰዎች ንገሩኝ?
9. ይህ/እኝህ ሰዎች እንደረዳችሁ/እንዲረዷችሁ ፈልጋችሁ ነበር?
10. እስቲ በወሊደ ሰዓት ማን እንደሚረዳችሁ ሲወሰነውን እነዴት እንደተወሰነ ንገሩኝ?
11. ስለ ልጅ መውልድዎ/መውለዳችሁ ምኑን ነው የወደዳችሁት?
12. ስለ ልጅ መውልድዎ/መውለዳችሁ ምኑን ነው የጠላችሁት?
13. በቀበሌያችሁ ሌሎች ሴቶች ስለ ልጅ መውለድ ምን ይላሉ?
14. የት መውለድ እንዳለባችሁ መወሠን ያለብት ማን ነው?
15. ሴቶች የት ነው መውለድ አለባቸው ብላችሁ የምታስቡት?
16. በወሊድ ሰዓት ማን እንዳሚረዳችሁ ማን መወሠን አለበት ብላችሁ ታስባለችሁ?
17. በቀበሌያችሁ ልጅ መውለድን ሂደት እንዴት የምቹ እና ጥንቃቄ የተሞላበት(ንፁህ) ማድረግ ይቻላል ብላችሁ ታስባለችሁ?

Schedule 6: Health extension workers (Amharic)



Interview guide / Interview with Health Extension workers/
ለጤና ኤክስቴንሽን ሠራተኞች የተዘጋጀ መጠይቅ

1. ለምን ያህል ጊዜ ለጤና ኤክስቴንሽን ሠራተኛ ሆነሻል? እንዴት ነው የጤና ኤክስቴንሽን ሠራተኛ የሆንሽው?ስራሽ ምን እንደሆነ ልትነግሪኝ /ልታብራሪ ትችያለሽ? ምን ያህል ሰው ለብቻሽ አዋልደሻል?ከሌሎች ለጤና ኤክስቴንሽን ሠራተኞች ምን ያህሉን አዋልደሻል?ከባህላዊ አዋላጆች ጋር ምን ያህል ሴቶችን አዋልደሻል? ቤት ለቤት በምታደርጊው ጉብኝት ማንን የምታዋሪው?ስለ ምን ታወሪያለሽ?ሴቶች ስለ ለጤና ኤክስቴንሽን ሠራተኞች ምን ይላሉ/ያላቸው ስሜት እንዴት ነው? ወንዶች ስለ ለጤና ኤክስቴንሽን ሠራተኞች ምን ይላሉ/ያላቸው ስሜት እንዴት ነው? በጤና ኬላ ውስጥ ለሚወልዱ ሴቶችን ለመርዳት ምን የመገልገያ መሳርሪያዎች /የሰው ሀይልን ጨምሮ/ አሉ? በጤና ተቋም/በጤና ኬላ/ለሚወልዱ ሴቶች ምን ዓይነት እርዳታ ይደረግላቸዋል? የጤና ኤክስቴንሽን ሠራተኛ እንደመሆንሽ መጠን ስለ ስራሽ ምን ይሰማሻል?

2. በማህረሰቡ ውስጥ ከሚኖሩ ሴቶች ጋር ምን ድን ነው ግንኙነትሽ/ግብብነትሽ? ስለ ጤና ኤክስቴንሽን ሠራተኞች ሴቶች ምን ይሰማቸዋል/ያስባሉ/ይላሉ?/ ወንዶችስ ስለ ጤና ኤክስቴንሽን ሠራተኞች ምንይላሉ/? ሴቶች ጤና ኬላ ሲደርሱ እንዴት ነው እንክብካቤ የሚደረግላቸው? ሴቶች በጤና ተቋም ስለመውለድ ምን ይላሉ/ስሜታቸው እንዴት ነው?በጤና ተቋም የሚወልዱ ሴቶችን መርዳት ምን ይመስላል/ምን ስሜት አለው? ወላድ ሴቶችን በጤና ኬላ እየረዳሽ/ስትረጂ የሚያጋጥምሽ ችግር አለ? ምን ያህል ሴቶችን ወደ ጤና ተቋም/ሆስፒታል ሪፈር ብለሻል? ወላድ ሴቶችን በምን ሰዓት ሪፈር ማለት እንዳለብሽ እንዴት ነው የምትወስኝው?ወላድ ሴቶች እንዴት ነው ወደ ሆስፒታል የሚተላለፉት? በትራንስፖርት ነው የሚሄዱት? በእግር ነው? ሪፈር ከተባሉ ሴቶች ጋር ወደ ጤና ተቋም አብረሽ ትመጪያለሽ?ጥንቃቄሽን/መከታተልሽን በጤና ጣቢያ ትቀጥያለሽ?ወደ ጤና ጣቢያ/ሆስፒታል የተላለፉት ሴቶች እዛ እንደደረሱ ወዲያው ክብካቤ/እርዳታ የሚደረገላቸው?የጤና ተቋሙ በቂ መሳሪያ፣መድሀኒትና ባለሙያዎች አሉት? ወላጅ ሴቶች በሚያገኙት እርዳታ ትረኪያለሽ?

3. ጥቂት ሴቶች በጤና ተቋም/ጤና ኬላ፣ጤና ጣቢያ/ሆስፒታል/ መውለድን ለምን ይመርጣሉ? ሌሎቹስ ለምን በቤት ውስጥ ይወልዳሉ? በዚህ በህብረተሰቡ ውስጥ ስለ ባህላዊ አዋላጆች ምን ታውቂያለሽ? ምን ይሰራሉ?ከባህላዊ አዋላጆች በተለየ ምን ታደርጋላችሁ? ለምንድን ነው ሴቶች ባህላዊ አዋላጆች ምክንያት በቤት ውስጥ የሚወልዱት ብለሽ ታስቢያለሽ?

4. ቤት ውሰጥ የሚወልዱ ሴቶችን እንዴት ነው የምትገልጫቸው /ስለነሱ የምታስረጂው /የምታብራሪው? በጤና ተቋም የሚወልዱ ሴቶች ምን ዓይነት ሴቶች ናቸው?

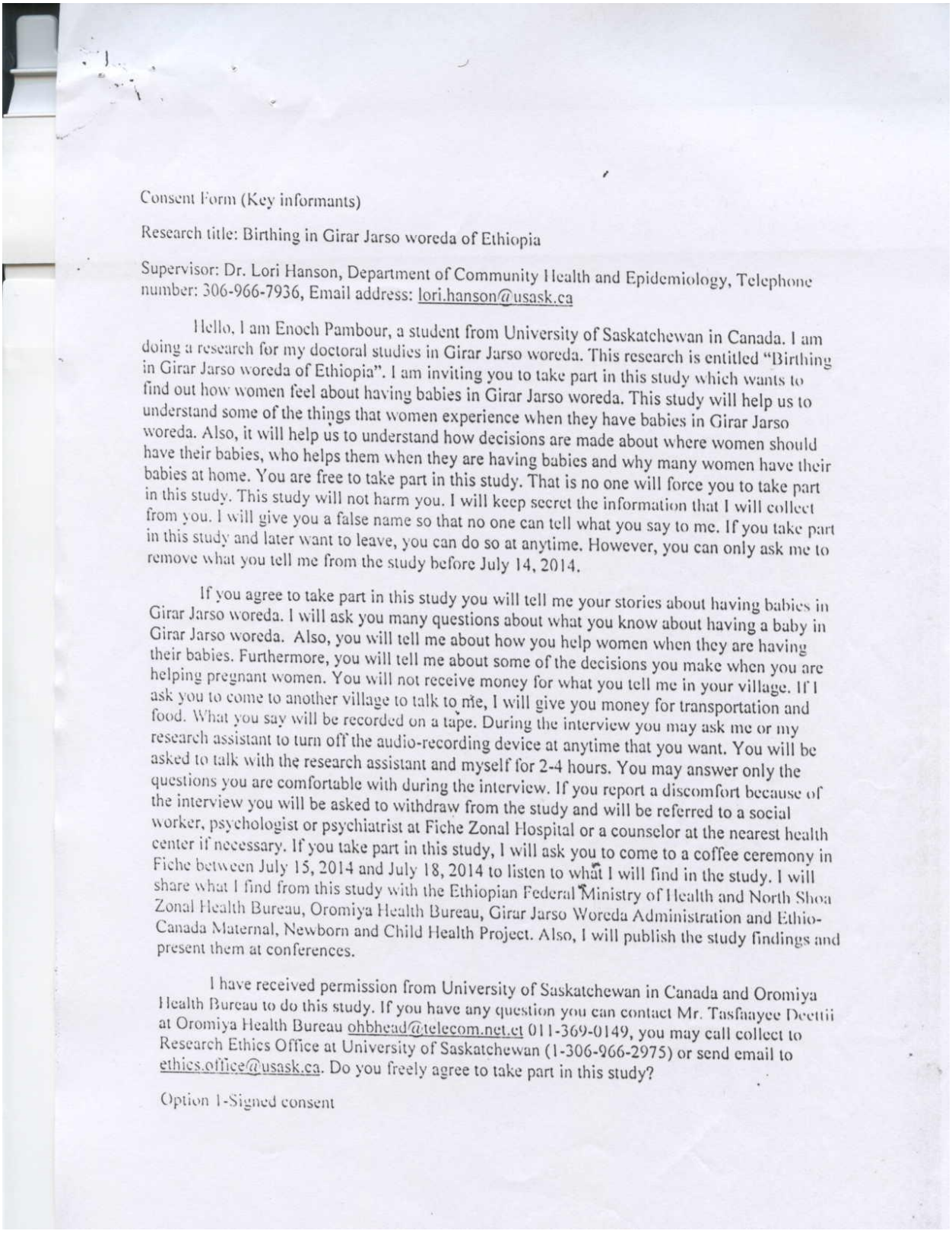
5. በባህላዊ አዋላጅና በጤና ኤክስቴንሽን ሠራተኞች መሀከል ግንኙነት/ግብብነት አለ? ባህላዊ አዋላጅና የጤና ኤክስቴንሽን ሠራተኞች የሚገናኙት እንዴት ነው?ጓደኛማችነት አለ ? የተባበሩበትን ጊዜ ልትነግሪኝ ትችያለሽ? የተጋጨቡበትን ጊዜ ልትነግሪኝ ትችያለሽ? በመሀከላቸው ያለው ግንኙነት ለወላድ እናቶች/ስለ ልጅ መውለድ/ የሚኖረው ጥቅም ነግሪኝ? በመሀከላቸው ጥሩ ግንኙነት ቢኖር ምን ይፈጠራል? በመካከላቸው መጥፎ ግንኙነት ቢኖርስ ምን ይሆናል?

6. በዚህ ማህረሰብ ውስጥ ከሴቶች በጤና ተቋም መውለድ ጋር በተያያዘ ጥሩ የተወሰኑ ልምዶች /መልካም/ማለፊያ/ የነበሩትን ልትነግሪኝ ትችያለሽ ? ከሴቶች በጤና ተቋም መውለድ ጋር በተያያዘ ጥሩ የተወሰኑ መጥፎ ልምዶች /ክፉ/ የነበሩትን ልትነግሪኝ ትችያለሽ? በወሊድ ሰዓት በጤና ተቋም የሞቱ ሴቶች አሉ?ምን ያህል?

7. በጤና ኬላው ውስጥ ሴቶችን በተሻለ ለመርዳት ይቻል ዘንድ አንቺ ማየት የምትፈልጊው ለውጥ ካለ አስቲ ንገሪኝ?

Appendix E: Consent forms

Schedule 1



Consent Form (Key informants)

Research title: Birthing in Girar Jarso woreda of Ethiopia

Supervisor: Dr. Lori Hanson, Department of Community Health and Epidemiology, Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca

Hello, I am Enoch Pambour, a student from University of Saskatchewan in Canada. I am doing a research for my doctoral studies in Girar Jarso woreda. This research is entitled "Birthing in Girar Jarso woreda of Ethiopia". I am inviting you to take part in this study which wants to find out how women feel about having babies in Girar Jarso woreda. This study will help us to understand some of the things that women experience when they have babies in Girar Jarso woreda. Also, it will help us to understand how decisions are made about where women should have their babies, who helps them when they are having babies and why many women have their babies at home. You are free to take part in this study. That is no one will force you to take part in this study. This study will not harm you. I will keep secret the information that I will collect from you. I will give you a false name so that no one can tell what you say to me. If you take part in this study and later want to leave, you can do so at anytime. However, you can only ask me to remove what you tell me from the study before July 14, 2014.

If you agree to take part in this study you will tell me your stories about having babies in Girar Jarso woreda. I will ask you many questions about what you know about having a baby in Girar Jarso woreda. Also, you will tell me about how you help women when they are having their babies. Furthermore, you will tell me about some of the decisions you make when you are helping pregnant women. You will not receive money for what you tell me in your village. If I ask you to come to another village to talk to me, I will give you money for transportation and food. What you say will be recorded on a tape. During the interview you may ask me or my research assistant to turn off the audio-recording device at anytime that you want. You will be asked to talk with the research assistant and myself for 2-4 hours. You may answer only the questions you are comfortable with during the interview. If you report a discomfort because of the interview you will be asked to withdraw from the study and will be referred to a social worker, psychologist or psychiatrist at Fiche Zonal Hospital or a counselor at the nearest health center if necessary. If you take part in this study, I will ask you to come to a coffee ceremony in Fiche between July 15, 2014 and July 18, 2014 to listen to what I will find in the study. I will share what I find from this study with the Ethiopian Federal Ministry of Health and North Shoa Zonal Health Bureau, Oromiya Health Bureau, Girar Jarso Woreda Administration and Ethio-Canada Maternal, Newborn and Child Health Project. Also, I will publish the study findings and present them at conferences.

I have received permission from University of Saskatchewan in Canada and Oromiya Health Bureau to do this study. If you have any question you can contact Mr. Tasfaayee Deettii at Oromiya Health Bureau ohbhead@telecom.net.et 011-369-0149, you may call collect to Research Ethics Office at University of Saskatchewan (1-306-966-2975) or send email to ethics.office@usask.ca. Do you freely agree to take part in this study?

Option 1-Signed consent

Your signature below indicates that you have read and understand the description provided; you have had an opportunity to ask questions and your questions have been answered. You agree to take part in this research project. A copy of this Consent Form has been given to you for your records.

Name of Participant Signature Date

Researcher or Research Assistant's Signature Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Option 2-Oral Consent

I read and explained this Consent Form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

Name of Participant Research Assistant's Signature Date

take part in the research project. A copy of this Consent Form has been given to you for your records.

Name of Participant Signature Date

Researcher or Research Assistant's Signature Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Option 2-Oral Consent

I read and explained this Consent Form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

Name of Participant Research Assistant's Signature Date

Schedule 2

Appendix A: Consent Form (In-depth interview)

Research title: Birthing in Girar Jarso woreda of Ethiopia

Supervisor: Dr. Lori Hanson, Department of Community Health and Epidemiology, Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca

Hello, I am Enoch Pambour, a student from University of Saskatchewan in Canada. I am doing a research for my doctoral studies in Girar Jarso woreda. This research is entitled "Birthing in Girar Jarso woreda of Ethiopia". I am inviting you to take part in this study which wants to find out how women feel about having babies in Girar Jarso woreda. This study will help us to understand some of the things that women experience when they have babies in Girar Jarso woreda. Also, it will help us to understand how decisions are made about where women should have their babies, who helps them when they are having babies and why many women have their babies at home. You are free to take part in this study. That is no one will force you to take part in this study. This study will not harm you. I will keep secret the information that I will collect from you. I will give you false name so that no one can tell what you say to me. If you take part in this study and later want to leave, you can do so at anytime. However, you can only ask me to remove what you tell me from the study before July 14, 2014. If you agree to take part in this study, you will tell me about how you felt and what you experienced when you had a baby in Girar Jarso woreda. Also you will tell me about how a decision was made about where to have your baby, who to attend to you and how you feel about all of that. What you say will be recorded on a tape. During the interview you may ask me or my research assistant to turn off the audio-recording device at anytime that you want. You will be asked to talk with the research assistant and myself for 2-4 hours. You may answer only the questions you are comfortable with during the interview. If you report a discomfort because of the interview you will be asked to withdraw from the study and will be referred to a social worker, psychologist or psychiatrist at Fiche Zonal Hospital or a counselor at the nearest health center if necessary. You will not receive money for what you tell me in your village. If I ask you to come to another village to talk to me, I will give you money for transportation and food. If you take part in this study, I will ask you to come to a coffee ceremony in Fiche between July 15, 2014 and July 18, 2014 to listen to what I will find in the study. I will share what I find from this study with the Ethiopian Federal Ministry of Health, North Shoa Zonal Health Bureau, Oromiya Health Bureau, Girar Jarso Woreda Administration and Ethio-Canada Maternal and Child Health Project. Also, I will publish the study findings and present them at conferences.

I have received permission from University of Saskatchewan in Canada and Oromiya Health Bureau to do this study. If you have any question you can contact Mr. Tasfaayee Deettii at Oromiya Health Bureau ohbhead@telecom.net.et 011-369-0149, you may call collect to Research Ethics Office at University of Saskatchewan (1-306-966-2975) or send email to ethics.office@usask.ca. Do you freely agree to take part in this study?

Option 1-Signed consent

Your signature below indicates that you have read and understand the description provided; you have had an opportunity to ask questions and your questions have been answered. You agree to

take part in the research project. A copy of this Consent Form has been given to you for your records.

Name of Participant Signature Date

Researcher or Research Assistant's Signature Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Option 2-Oral Consent

I read and explained this Consent Form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

Name of Participant Research Assistant's Signature Date

Appendix F: Ethics letter

With the support of a research assistant, I reiterated the purpose of the meeting to participants on each day of interview. Before the start of each interview a research assistant read and explained the content of the consent form in the participants' mother tongue (Amharic or Oromic) and told them to ask any questions they had about the study or express their concerns. With the support of a research assistant I answered all participants' questions and clarified their concerns. The research assistant informed participants of their right to answer only questions they were comfortable with and their right to withdraw from the interview at any time if they so desired. However, participants were told that they could only ask me to remove the information they shared in the interview from the study not later than July 14, 2014. It was believed that beyond this date some form of research dissemination would have occurred and would be impossible to retract participants' data. Participants were told that they had the right to ask me or my research assistant to turn off the audio-recorder at any point in the interview. Each participant was given a pseudonym to conceal their identity before interviews began. Permission was asked from participants to audio-record their interviews. Participants were informed that audio-recordings will be digitally erased five (5) years after the completion of the study as per University of Saskatchewan Research Ethics Board requirement. Also participants were told that recordings would only be used for research purposes and would be accessible to the research team and my supervisor. In addition, the research assistants informed participants that they and I would keep their information secret. However, a research assistant told participants that we could not guarantee that other women in the focus group discussions would not disclose what they said. Before the start of each focus group discussion or in-depth interview, a research assistant read and explained the consent form to participants (in Amharic or Oromic) and told them to ask any questions they had about the study or vent their concerns. Written or oral consent was obtained from participants after my research assistants and I had thoroughly answered participants' questions and addressed their concerns.

Appendix G: Letter from U of S Behavioral Research Ethics Board

Radcliffe, Beryl

Fri 2014-11-28 2:23 PM
Inbox
To:
Pambour, Enoch;
...
Cc:
Hanson, Lori;
...
You replied on 2014-11-29 5:05 AM.

Hi Enoch, I discussed this with Dr. Hanson and we are both comfortable with the elder follow up and not requiring consent. Although somewhat different from the usual professional practice, I interpret your questions to the elders as complying with the following:

Exemption Article 2.1 states "research may involve interaction with individuals who are not themselves the focus of the research in order to obtain information. For example, one may collect information from authorized personnel to release information or data in the ordinary course of their employment about organizations, policies, procedures, professional practices or statistical reports. Such individuals are **not considered participants** for the purposes of this Policy. This is distinct from situations where individuals are considered participants because they are themselves the focus of the research.

Best wishes,

Beryl Radcliffe B. Sc. CCRP
Ethics Specialist (Behavioural)
Research Ethics Office
Phone: 306-966-2084

1602 - 110 Gymnasium Place
Saskatoon, Saskatchewan S7N 0W9
NRC/PBI Building (map available)

Appendix H: Transcript release form

Appendix E: Transcript Release Form

Project title: Birthing in Girar Jarso woreda of Ethiopia

Researcher: Enoch Pambour, Graduate student, Department of Community Health and Epidemiology, University of Saskatchewan, Telephone number: 306-979-5904, Email address: eap809@mail.usask.ca

Supervisor: Dr. Lori Hanson, Department of Community Health and Epidemiology, Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca

I,----------,waive my right to review the transcript of my personal interview in this study, and have agreed for Enoch Pambour to use it in accordance with the ethical requirements that apply to his research study. I hereby authorize the release of my interview transcript to Enoch Pambour to be used in the manner described in the Consent Form. I have received a copy of this Transcript Release Form for my own records.

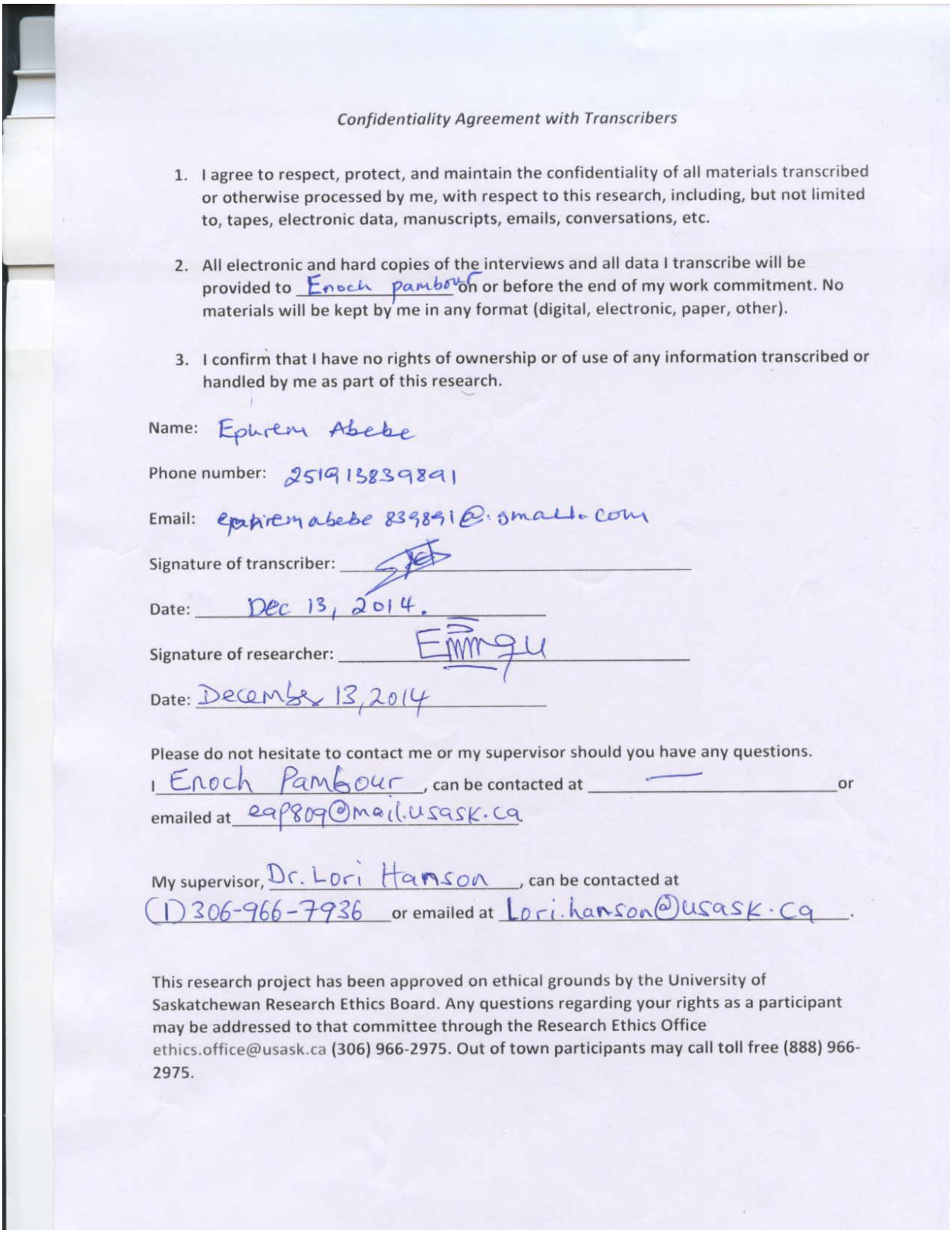
Name of Participant

Date

Signature of Participant

Signature of Researcher

Appendix I: Confidentiality agreement



Confidentiality Agreement with Transcribers

1. I agree to respect, protect, and maintain the confidentiality of all materials transcribed or otherwise processed by me, with respect to this research, including, but not limited to, tapes, electronic data, manuscripts, emails, conversations, etc.

2. All electronic and hard copies of the interviews and all data I transcribe will be provided to Enoch pambour on or before the end of my work commitment. No materials will be kept by me in any format (digital, electronic, paper, other).

3. I confirm that I have no rights of ownership or of use of any information transcribed or handled by me as part of this research.

Name: Ephrem Abebe

Phone number: 251913839891

Email: ephremabebe839891@gmail.com

Signature of transcriber: _____

Date: Dec 13, 2014.

Signature of researcher: Emmgu

Date: December 13, 2014

Please do not hesitate to contact me or my supervisor should you have any questions.

I Enoch Pambour, can be contacted at —— or emailed at eap809@mail.usask.ca

My supervisor, Dr. Lori Hamson, can be contacted at (1) 306-966-7936 or emailed at Lori.hamson@usask.ca.

This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.